

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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9709

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09623

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown RFD				c. LENGTH OF STAY IN 1b 3 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Home for the Aged				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 420 No Locust St							
3. NAME OF DECEASED (Type or print) First MARY Middle FUSS Last ANGLE				4. DATE OF DEATH Month August Day 3 Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1863	
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 9 Days 7 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Fuss		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George F. Bell		Address 1127 Hamilton Blvd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy - Abdominal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 199.1 DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 18, 1960 to Aug. 2, 1960 , that (I) (we) last saw the deceased alive on Aug. 2, 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. A. Hoffman				22b. DATE SIGNED Aug. 3 - 60		22c. PHYSICIAN'S NAME (Type) Dr. A. Hoffman	
22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR Aug 5 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

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9652

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09624

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 24 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle May Last Baker		4. DATE OF DEATH Month August Day 26 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1882
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Edgewood Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah Francklin		14. MOTHER'S MAIDEN NAME Catherine Warner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frank S. Baker		Address Hagerstown Md 26 Roessner Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1958 to August 26, 1960 , that (I) (we) last saw the deceased alive on August 25, 1960 , and that death occurred at 1:54 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. E. W. Ditto, Jr. M.D.		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-29-60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR AUG 31 '60	
ADDRESS Hagerstown Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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CERTIFICATE OF DEATH

Reg. Dist. No.

09625

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WELTY Middle JAMES Last BAKER, JR.				4. DATE OF DEATH Month August Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1910		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scrap Dealer		10b. KIND OF BUSINESS OR INDUSTRY Scrap		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Welty J. Baker Sr.				14. MOTHER'S MAIDEN NAME Dora Mongan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) NW 2		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address Mrs. W. J. Baker 1157 Corbett St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemorrhage 572-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ulcerative colitis DUE TO (c) 6 months						INTERVAL BETWEEN ONSET AND DEATH 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 to 1960 , that I last saw the deceased alive on Aug 12 , 19 60 , and that death occurred at 1:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. N. Weeks			M.D. 136 N. Potomac St. Hagerstown, Md.		ADDRESS (Street, city or town, state) HAGERSTOWN		
PHYSICIAN'S NAME (Type) H. N. WEEKS			M.D. H. N. WEEKS		DATE SIGNED 8/13/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/60		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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Wm. G. Horst

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09626

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Pargan c. LENGTH OF STAY IN 1b a few Hrs			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown d. STREET ADDRESS Moller Cross Roads e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) WALTER ARMSTRONG BARB First Middle Last			4. DATE OF DEATH August 24 1960 Month Day Year		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16 1943 Month Day Year		9. AGE (In years last birthday) 16 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) In School		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va. Mollers Cross Rd	
13. FATHER'S NAME Thomas Lee Barb			14. MOTHER'S MAIDEN NAME Edna DeLauder		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas L. Barb Address Shepherdstown W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DROWNING 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATHER STATES CHILD HAS HAD FREQUENT EPILEPTIC SEIZURES				INTERVAL BETWEEN ONSET AND DEATH INSTANT	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) LATELY DROWNED WHILE PLAYING TAG IN POTOMAC RIVER			
20c. TIME OF INJURY Month, Day, Year 4:00 a.m. 8-24 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) POTOMAC RIVER	
20f. (City or town) Below		20g. (County) Jefferson		20h. (State) W. VA.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE DR. E.W. DITTO, JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED AUG. 24, 1960	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/60		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	
22d. LOCATION (City, town, or county) Shepherdstown W. Va.		22e. (State) Jefferson Co		22f. (Country) W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			24a. REC'D BY REGISTRAR AUG 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hens

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Aug. 5, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 9/59

9654

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09627

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Antrim Twp. 7543</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>WINTFERD</u> Last <u>BARNHART</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min.		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. md. RR.</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>J. Clinton Barnhart</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Danner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>705-10-7427</u>				17. INFORMANT <u>Mrs. Florence Barnhart</u> Address <u>Greencastle Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema--cor pulmonale syndrome</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/39</u> to <u>8/6/60</u> , that (I) (we) last saw the deceased alive on <u>8/6/60</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Brewer</u> M.D.				22b. DATE SIGNED <u>8/8/60</u>		22c. PHYSICIAN'S NAME (Type) <u>William C. Brewer M.D.</u>	
22d. ADDRESS <u>359 East Baltimore Greencastle, Pa.</u>				22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>				23b. DATE THEREOF <u>8/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cem.</u>	
23d. LOCATION (City, town, or county) <u>Franklin Co., Pa.</u>				23e. REGISTRAR'S SIGNATURE		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.C. Minnich - Greencastle, Pa.</u>							

IN SENATE

January 12, 1909

REPORT OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1908

ALBANY:

1909

PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

ALBANY

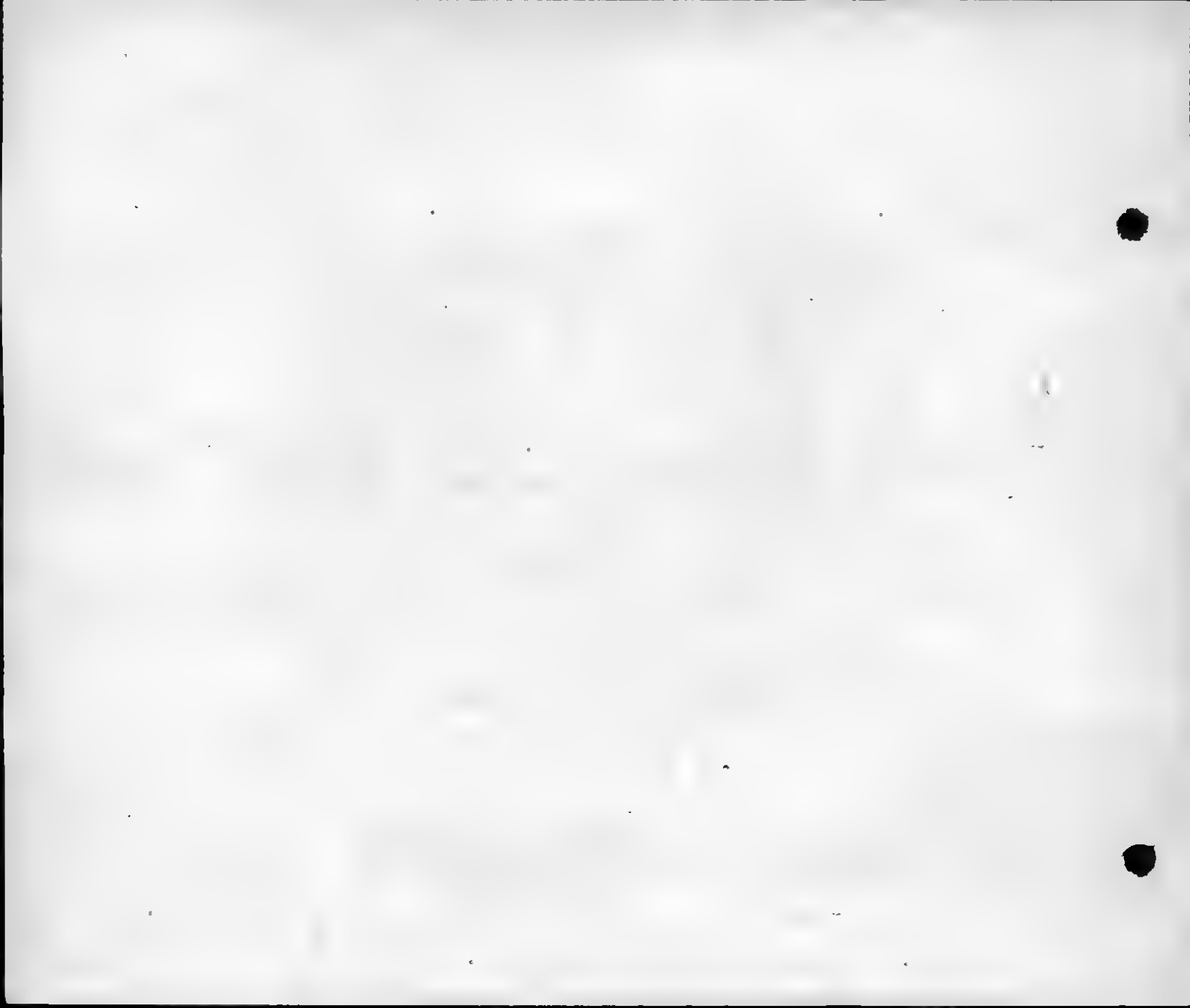
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9711

09628

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Funkstown			
c. LENGTH OF STAY IN 1b 85 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 E. Baltimore				d. STREET ADDRESS 312 E. Baltimore			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Violetta Virginia McCoy Barnhart				4. DATE OF DEATH August 30 19 69			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13, 1872	
9. AGE (In years and birthday) 88 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Martin Luther Miller				14. MOTHER'S MAIDEN NAME Laura Earick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ethel Warrenfeltz Funkstown Ind.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Heart D. 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Thrombosis due to arterio-sclerosis (c) Cerebral Thrombosis due to arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 6, 1960 to Aug 31, 1960 that (I) (we) last saw the deceased alive on Aug 24, 1960 and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Sidney Novenstein				22b. DATE SIGNED 8-30-69		22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN	
				22d. ADDRESS FUNKSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-1-60		23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City, town, or county) (State) Funkstown Ind.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Ind.		25a. REC'D BY REGISTRAR DATE SEP 2 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

9712

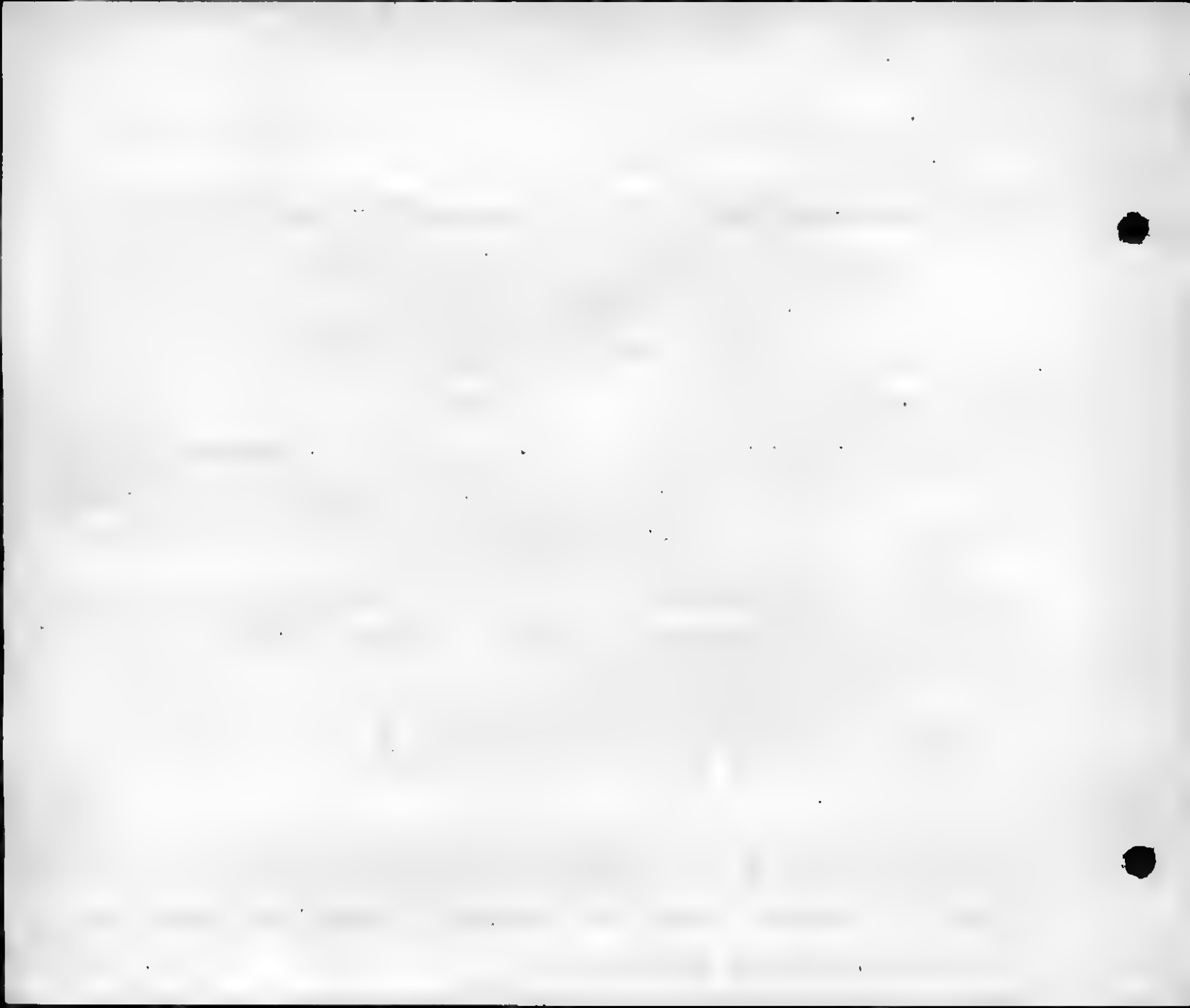
09629

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#2 c. LENGTH OF STAY IN 1b 11 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport-Greencastle Pike				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS Williamsport-Greencastle Pike e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JESSIE IRENE BELL First Middle Last			4. DATE OF DEATH August 13 1960 Month Day Year				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3 1980 Yrs	9. AGE (In years last birthday) 80 Yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) County Nebraska 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Milo Fales			14. MOTHER'S MAIDEN NAME Hattie Youkem				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Hattie Munson, Hagerstown R#1 Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 7/10.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Paralytic Ileus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture femur left, Senility, Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/23 19 57 to 8/13/60 19 60 , that (I) (we) last saw the deceased alive on 8/10 19 60 , and that death occurred at 445 AM from the causes and on the date stated above.							
22a. SIGNATURE Robert V. L. Campbell		22b. DATE SIGNED 8/15/60		22c. PHYSICIAN'S NAME (Type) ROBERT V. L. Campbell			
22d. ADDRESS HAGERSTOWN Md		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/15/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman, Hagerstown Md					
25a. REC'D BY REGISTRAR AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Knaus					

(M)

X

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

9655

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

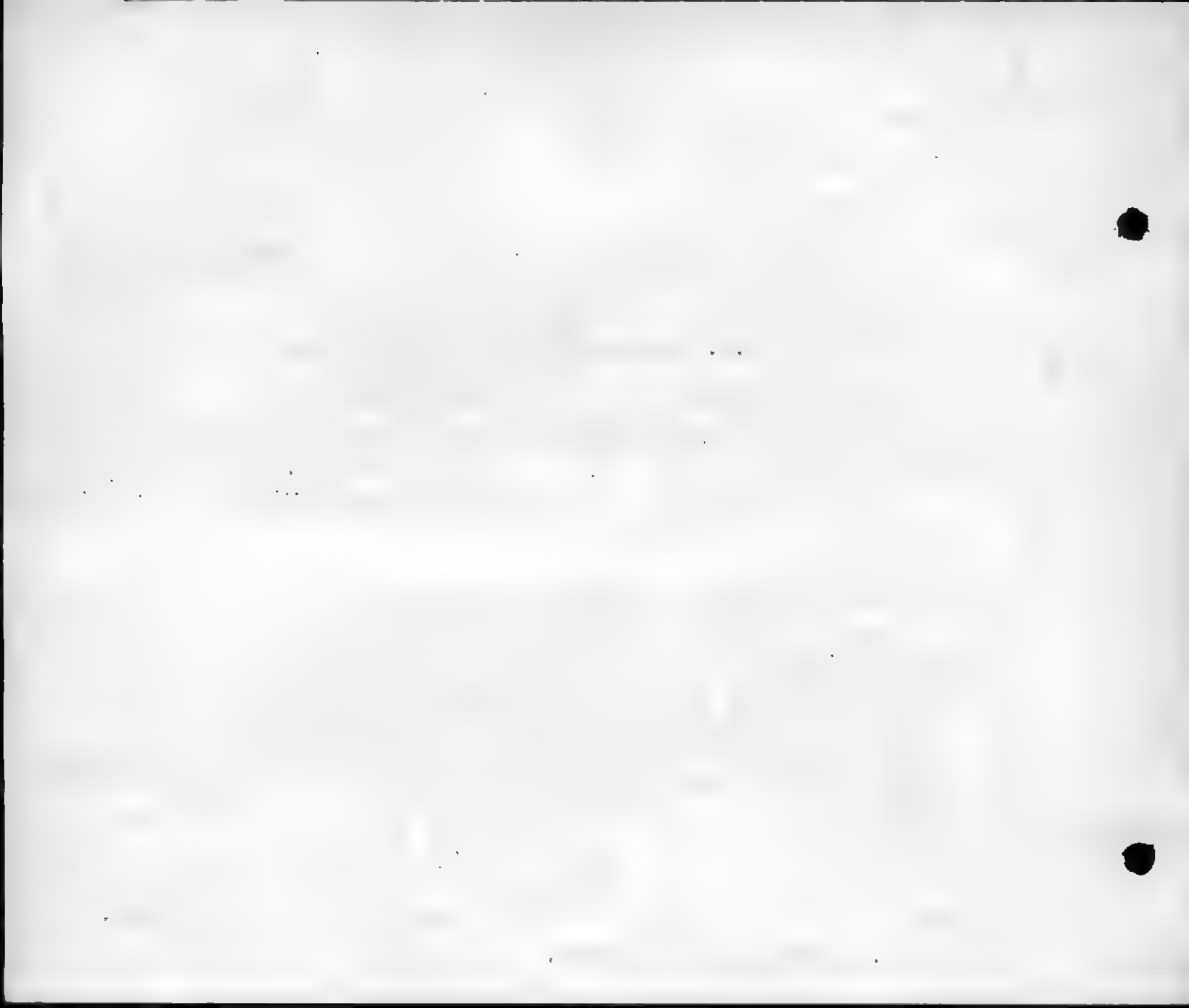
09630

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 13 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 Potomac Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1810 Potomac Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES CLINTON BINGAMAN				4. DATE OF DEATH Month Day Year August 18 1960 19			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 29 1897		9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miller		10b. KIND OF BUSINESS OR INDUSTRY D.A. Stiockell Sons		11. BIRTHPLACE (State or foreign country) Pa Greencastle Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Bingaman				14. MOTHER'S MAIDEN NAME Cora Cosey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-6374		17. INFORMANT Mrs Clara Bingaman 810 Potomac Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease with auricular Fibrillation DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1959 to 18 Aug 1960 , that (I) (we) last saw the deceased alive on 15 Aug 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE F F Lusby				22b. DATE SIGNED 19 Aug 60			
22c. PHYSICIAN'S NAME (Type) F F Lusby				22d. ADDRESS 2301 Potomac			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown Wash Co Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE AUG 23 '60		25b. REGISTRAR'S SIGNATURE W. S. Lusk	

(M)

X

(I)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

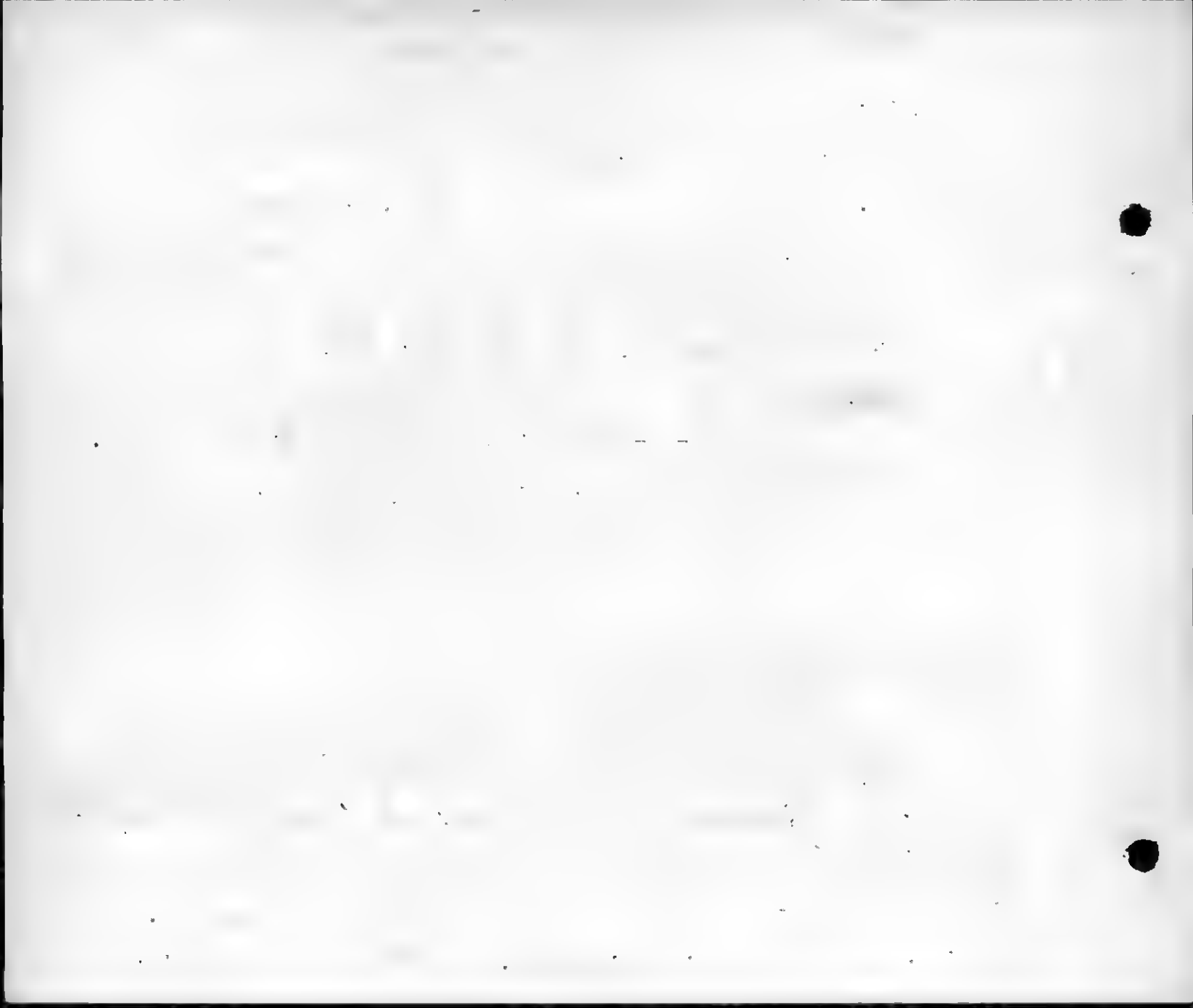
9656

CERTIFICATE OF DEATH

09631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>60 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 W. Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>22 W. Baltimore</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Benjamin Fechtig Bond</u>		4. DATE OF DEATH Month Day Year <u>August 24 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1878</u>
9. AGE (In years last birthday) <u>82</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knitting Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Carlisle Illinois</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jerome Bond</u>		14. MOTHER'S MAIDEN NAME <u>Mary Franer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-09-9498a</u>	
INFORMANT Address <u>Mrs. Alta Bond Hagerstown Md.</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>60</u> , to <u>August 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 17</u> , 19 <u>60</u> , and that death occurred at <u>4:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Jennings</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 136 W. Washington St Hagerstown, Md. 8/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son Hagerstown Md.</u>		ADDRESS <u>24a. REC'D BY REGISTRAR</u> <u>24b. REGISTRAR'S SIGNATURE</u> <u>AUG 26 '60</u> <u>Arthur S. Hume</u>	



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

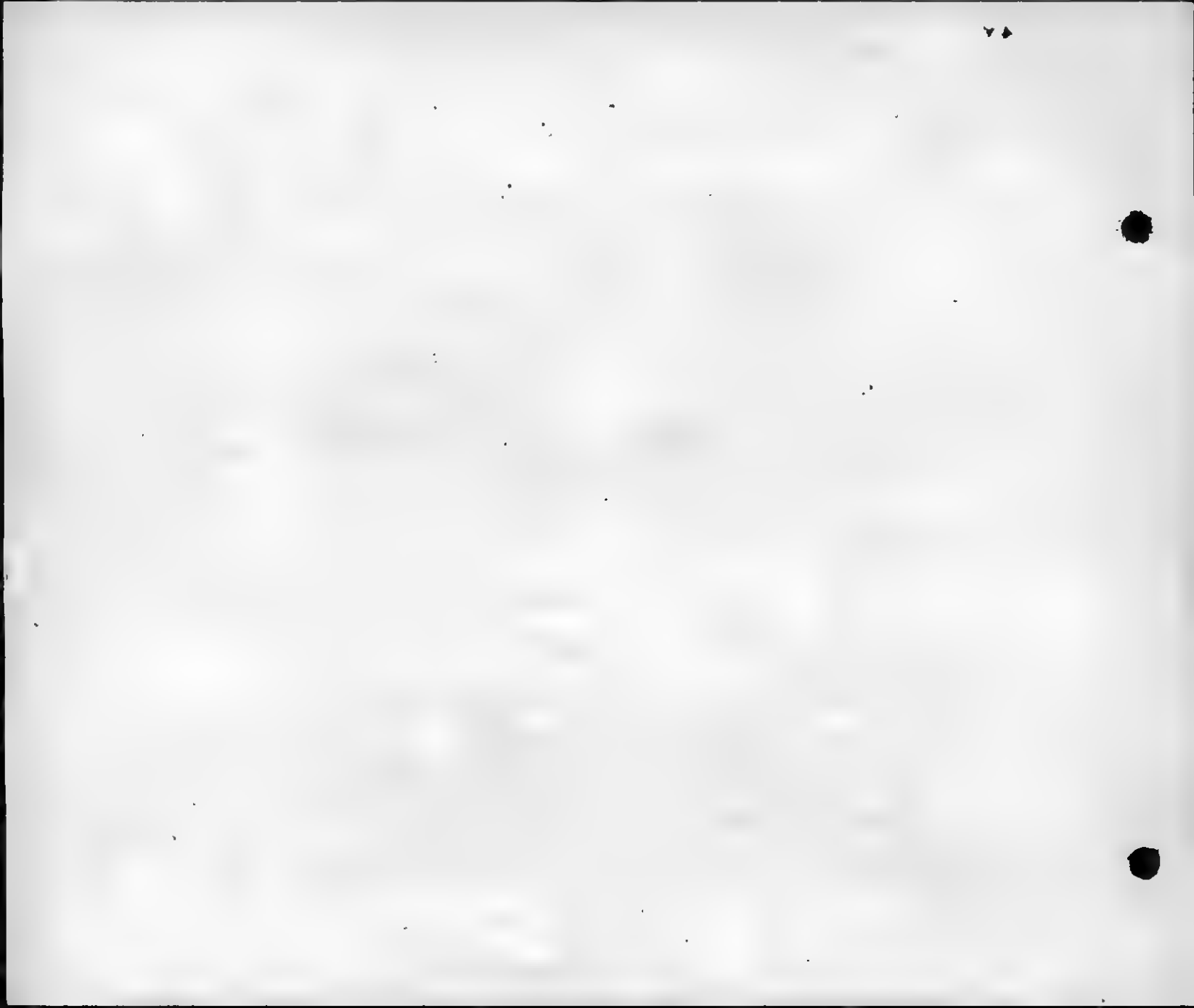
9657

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09652

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last BRADY				4. DATE OF DEATH Month AUGUST Day 29 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/28/60	
9. AGE (In years last birthday) 1 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FOREST L. BRADY				14. MOTHER'S MAIDEN NAME RUTH D. ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ALICE ROBINSON		18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7767 Prematurity DUE TO (b) 2 day DUE TO (c) 2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/28/60 19 to 8/29/60 19, that (I) (we) last saw the deceased alive on 8/29/60 19, and that death occurred at 7 P M, from the causes and on the date stated above							
22a. SIGNATURE Searl Young		22b. PHYSICIAN'S NAME (Type) SEARL YOUNG		22c. ADDRESS 143 N. POTOMAC ST. HAGERSTOWN MD.		22d. DATE SIGNED 8/30/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/30/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.				25. REC'D BY REGISTRAR SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

Now



9658

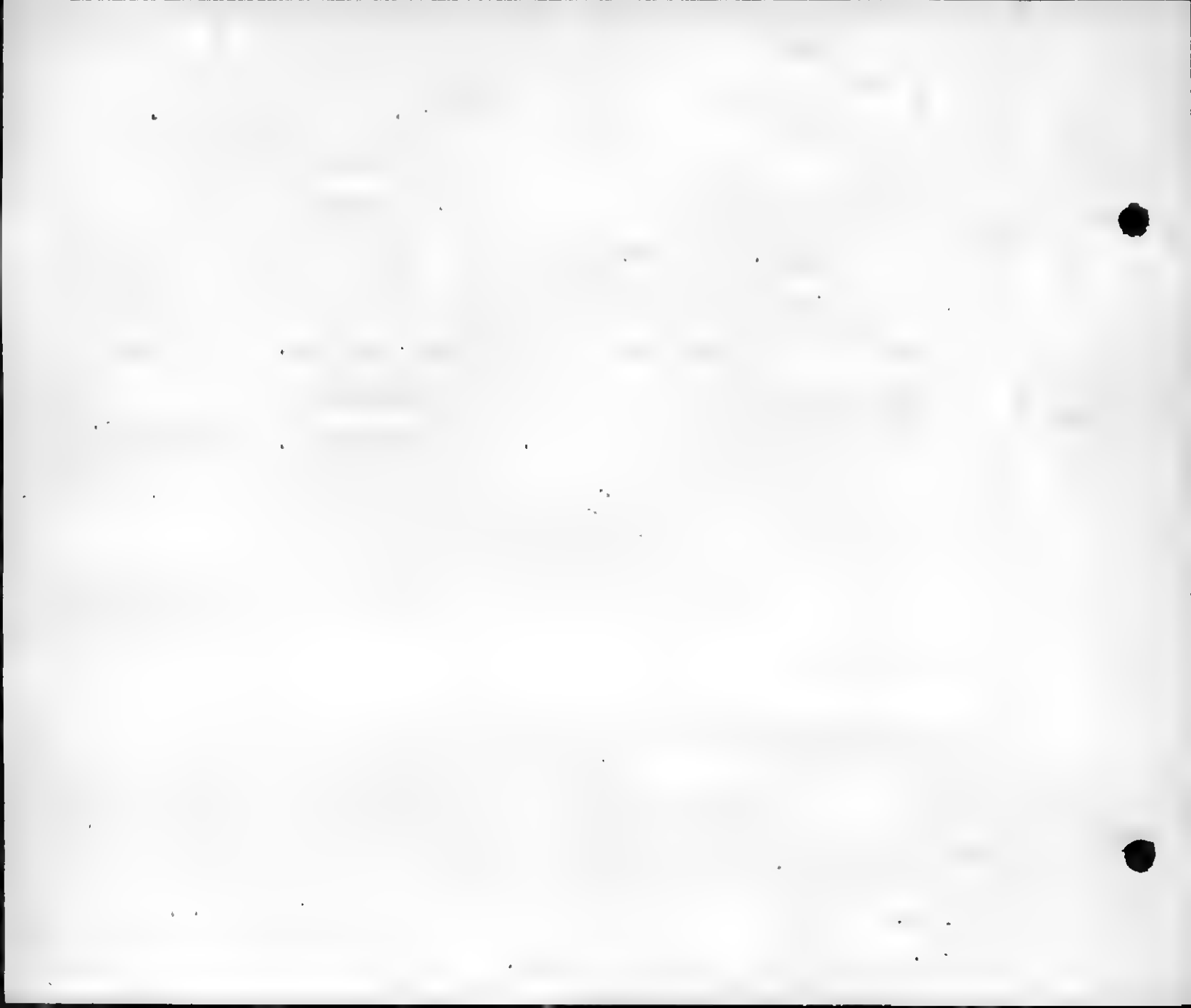
CERTIFICATE OF DEATH

09653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 17 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First T. Middle SCOTT Last BUHRMAN		4. DATE OF DEATH Month Aug Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1887
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher		10b. KIND OF BUSINESS OR INDUSTRY Magazine	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Buhrman		14. MOTHER'S MAIDEN NAME Jennie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Pa. Mrs. Hazel Buhrman, 24 W. 2nd St., Waynesboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis C.V.D. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) gen'l arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH sev years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/13/60 , 19 60 , to 8/4/60 , 19 60 , that I last saw the deceased alive on 7/22/60 , 19 60 , and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 North Potomac Street, 8/5/60 DATE SIGNED			
ACTUAL SIGNATURE Howard N. Weeks M.D.		PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/8/60	22c. NAME OF CEMETERY OR CREMATORY Lee Crematory	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Poe		ADDRESS Waynesboro, Penna.	24a. REC'D BY REGISTRAR DATE AUG 8 '60
		24b. REGISTRAR'S SIGNATURE Charles S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13
FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09634									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> d. STREET ADDRESS <u>Wabash St.</u>				
3. NAME OF DECEASED (Type or print) <u>Donald Franklin Burnett</u>					4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1960</u>				
5. SEX <u>M</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>April 10, 1927</u>				
9. AGE (in years last birthday) <u>33</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Mins.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>					12. KIND OF BUSINESS OR INDUSTRY <u>Restaurant & liquor store</u>				
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>					14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
15. FATHER'S NAME <u>Charles H. Burnett</u>					16. MOTHER'S MAIDEN NAME <u>Lillie Ganor</u>				
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War II</u>					18. SOCIAL SECURITY NO. <u>Informant</u>				
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Of Aorta, Ruptured</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemopericardium</u> DUE TO (c) <u>Pulmonary Congestion & Edema</u>					20. INTERVAL BETWEEN ONSET AND DEATH <u>3 Hours</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					26. (City or town) (County) (State)				
27. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
28. ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>					29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
30. EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>					31. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					33. DATE SIGNED <u>8-23-60</u>				
34. ADDRESS (Street, city, town, or county)					35. (State)				
36. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					37. DATE THEREOF <u>8-25-60</u>				
38. NAME OF CEMETERY OR CREMATORY <u>Alpine E.B. Cemetery</u>					39. LOCATION (City, town, or county) <u>Hancock</u> (State) <u>West Virginia</u>				
40. FUNERAL DIRECTOR <u>Edward F. Stone</u>					41. ADDRESS <u>Hancock, Md.</u>				
42. RECD BY REGISTRAR <u>Arthur S. House</u>					43. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>				
44. DATE <u>AUG 29 '60</u>					45. (State)				



9713

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

09665

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE - RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BENEVOLE - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.I.</u>				d. STREET ADDRESS <u>BOONSBORO MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LETTY LEE CASTLE</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 13 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13 - 1924</u>	9. AGE (In years last birthday) <u>36 yrs</u>	10. IF UNDER 1 YEAR Months Days Hours Min <u>3 10</u>		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HOWARD D. LIGHTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE B. SPRINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-22-7884</u>		17. INFORMANT Address <u>ARLINGTON R. CASTLE BOONSBORO MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>411X</u> DUE TO <u>Acute fulminant Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease with</u> (c) <u>aortic Stenosis and insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>June 7 1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1960</u> to <u>August 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>August 13, 1960</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>				22d. ADDRESS <u>21 North Main Street Boonsboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG. 16, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Secondari</u>				ADDRESS <u>Boonsboro MD</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

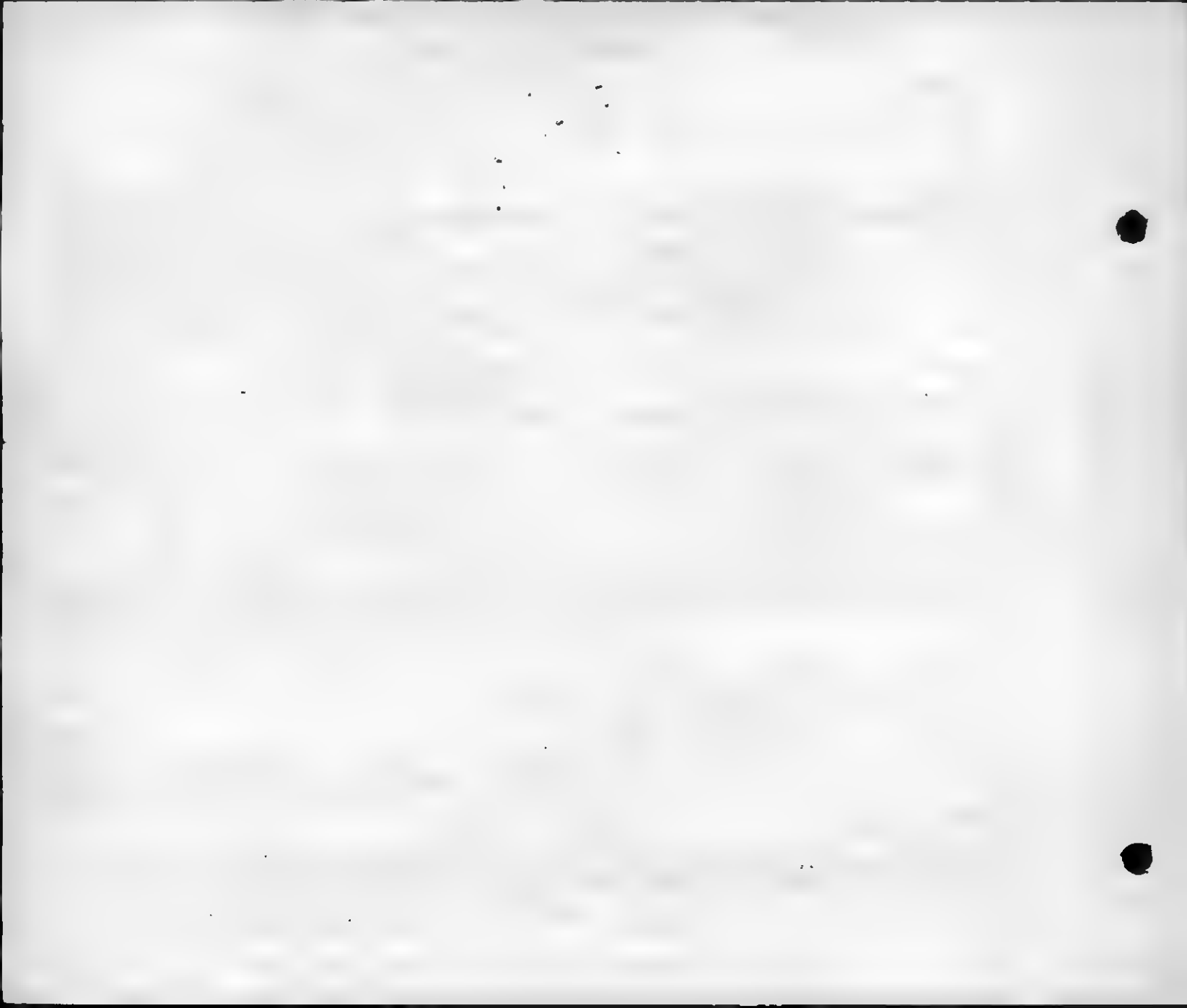
9660 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS R.F.D. 5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Churchey		4. DATE OF DEATH Month Aug. Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1960
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. 1 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur McKinley Churchey		14. MOTHER'S MAIDEN NAME Mildred Irene Lushbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 8, 1960, to Aug. 8, 1960, that I last saw the deceased alive on Aug. 8, 1960, 12, and that death occurred at 10:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edward W. Ditto M.D.			
PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. 217 W. Washington St., Hag., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/12/60	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hosp. Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward W. Ditto III		ADDRESS	
24a. REC'D BY REGISTRAR DATE AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

208/372XV0



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

9714

Reg. Dist. No.

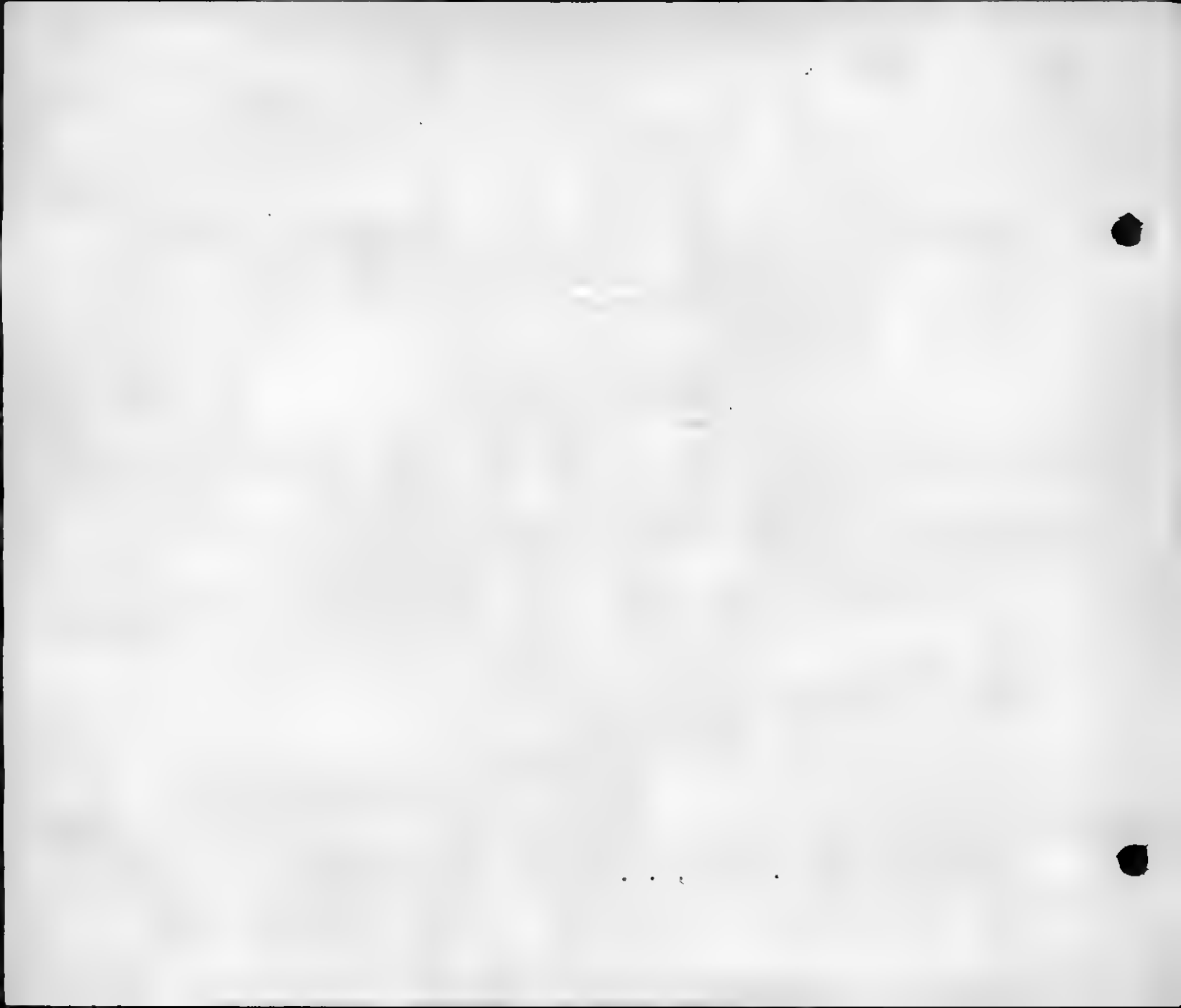
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If inst. lation. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE RURAL ONE DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALKERSVILLE RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KEEDYSVILLE MD. R.I.</u>		d. STREET ADDRESS <u>WALKERSVILLE MD. R.I.</u>	
3. NAME OF DECEASED (Type or print) <u>TERESA MARIE CLARK</u>		4. DATE OF DEATH <u>AUGUST 31 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30 1960</u>
9. AGE (In years last birthday) <u>6</u> yrs		10. IF UNDER 24 HRS. Months <u>4</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>HAROLD CLARK</u>		14. MOTHER'S MAIDEN NAME <u>PATSY MOATS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>HAROLD CLARK</u>		Address <u>WALKERSVILLE FRED. COMD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia viral & aspiration pneum.</u> Sudden			
DUE TO (b) <u></u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		Acting Medical Examiner	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOCUST GRAVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Dickhaut</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Friend</u>	

208/213XV6



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

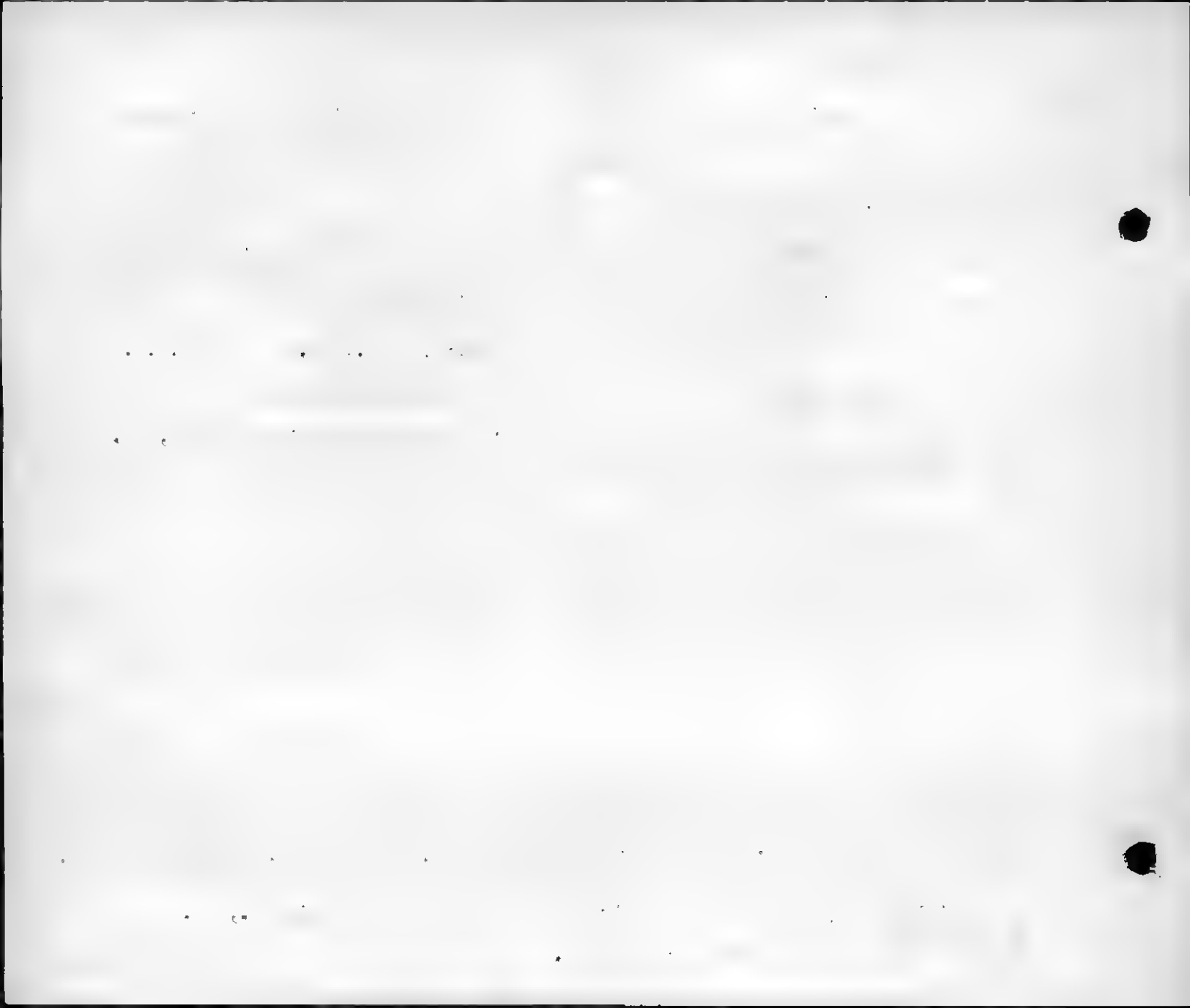
9715

CERTIFICATE OF DEATH

Item 9-1116269-8-25-60 et

19657

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chambersburg	
c. LENGTH OF STAY IN lb 5 months		d. STREET ADDRESS 154-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle KATE Last COBLE		4. DATE OF DEATH Month August Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1881
9. AGE (In years last birthday) 78 79 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Franklin Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Coble		14. MOTHER'S MAIDEN NAME Elizabeth Zarger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Sellers Funeral Home		Address Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac coronary DUE TO (b) arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 day yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from seen in house by Dr. Brewster 10/13/60 (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 8/15/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/1960	
23c. NAME OF CEMETERY OR CREMATORY Coble's Cemetery		23d. LOCATION (City, town, or county) (State) Franklin Co., Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Sellers Funeral Home		ADDRESS Chambersburg, Pa.	
25a. REC'D BY REGISTRAR Aug 23 '60		25b. REGISTRAR'S SIGNATURE Charles E. Hensel	



9716

CERTIFICATE OF DEATH

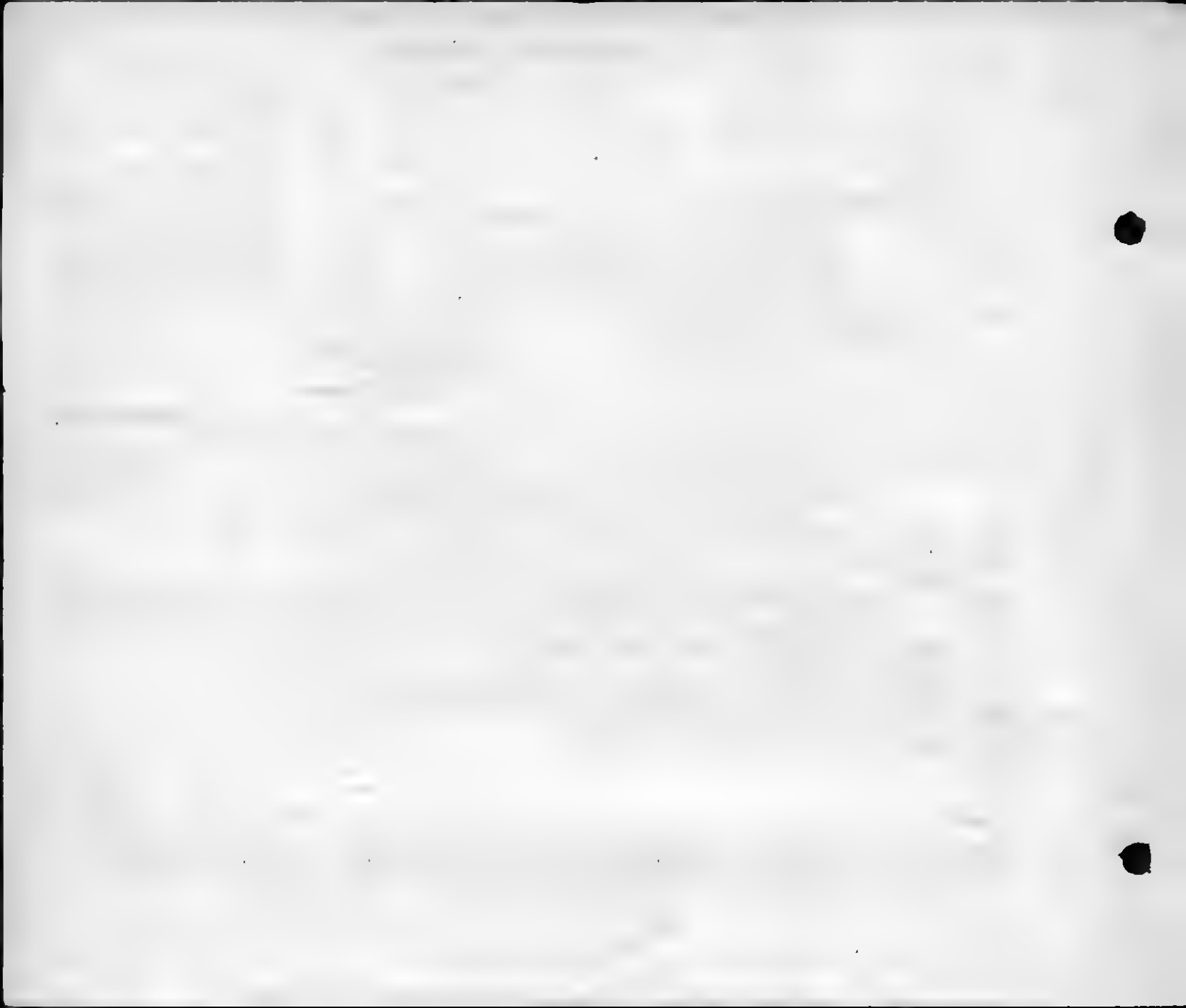
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 224 Norway Ave.			
3. NAME OF DECEASED (Type or print) First MALINDA Middle ELLA Last COFFMAN				4. DATE OF DEATH Month August Day 9 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1870	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elkton, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Dean				14. MOTHER'S MAIDEN NAME Sarah Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hagerstown, Md. Mrs. Nora L. Gochenour 224 Norway Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. myocardial infarction 420.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to (c) interval between onset and death							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/9/60 , 19 60 , to 8/9/60 , 19 60 , that I last saw the deceased alive on 8/9/60 , 19 60 , and that death occurred at 7:25 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Williamsport, Md. 101 E. Potomac St. DATE SIGNED 8/9/60							
ACTUAL SIGNATURE Ralph F. Young M.D.				M.D. William Spool M.D.			
PHYSICIAN'S NAME (Type) Ralph F. Young M.D.				Williamsport, Md. 101 E. Potomac St.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Wm. G. Frost

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9717

CERTIFICATE OF DEATH

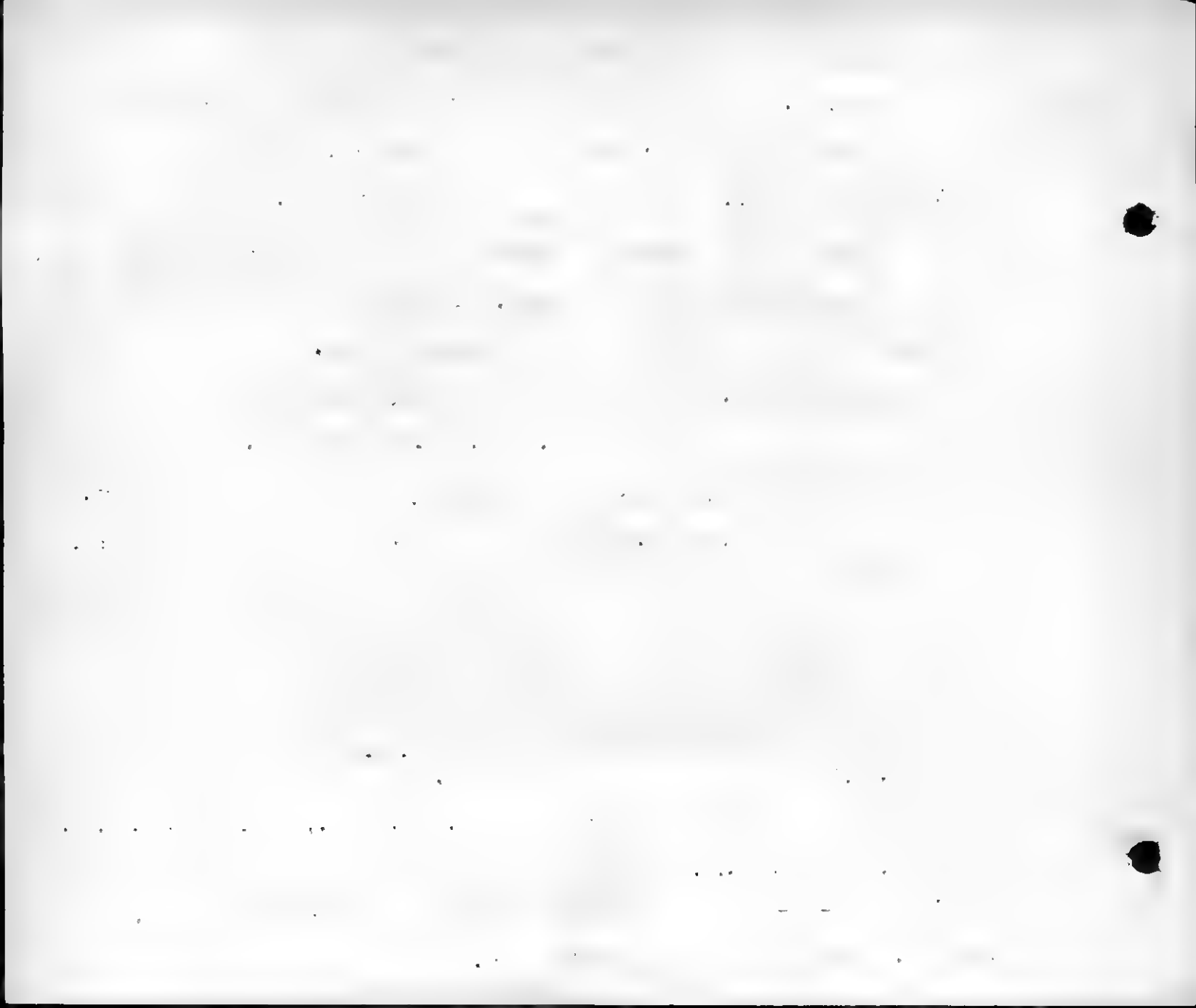
09630

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) College Road Rt. 3		e. STREET ADDRESS 658 Virginia Ave.	
3. NAME OF DECEASED (Type or print) First Thomas Middle Robert Last Conner		4. DATE OF DEATH Month August Day 13 Year 19 60	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1898
9 AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Garage	
11. BIRTHPLACE (State or foreign country) Chicago Ill.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip M. Conner		14. MOTHER'S MAIDEN NAME Mary Ann Heist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. Mr. Irvin T. Miller Rt. 3	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 wks. 1 year.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1935 , 19____, to 8.13.60 , 19____, that I last saw the deceased alive on 8.13.60 , 19____, and that death occurred at 9.10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. Earl Young M.D. M.D. 148 N. Potomac St., Hagerstown, Md. 8.13.60			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) S. Earl Young M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-60	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9718

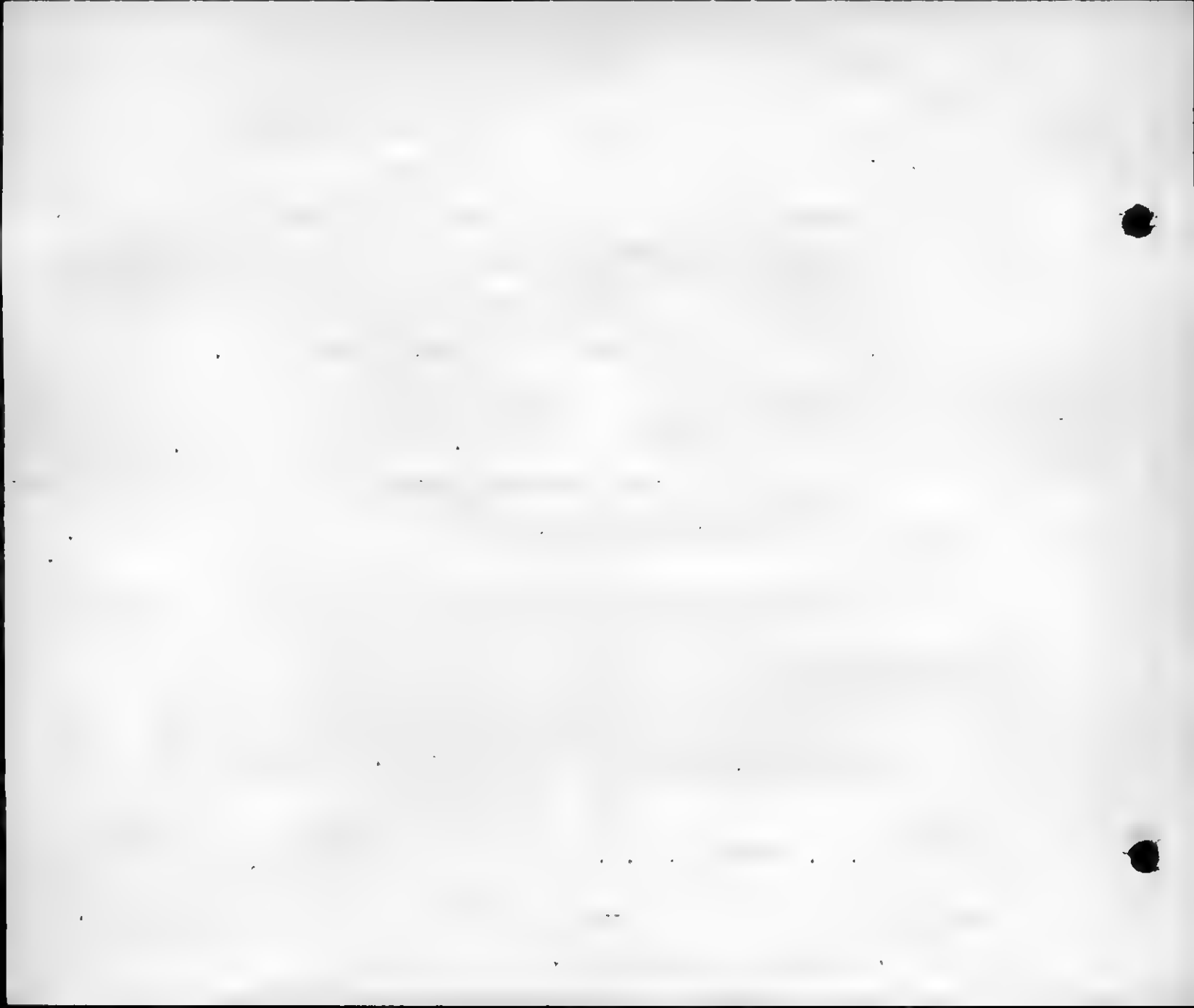
CERTIFICATE OF DEATH

302

09040

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6 c. LENGTH OF STAY IN lb 11 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Middleburg Pike		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6 d. STREET ADDRESS Middleburg Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUDE NORVY COOK		4. DATE OF DEATH August 25 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1887 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Thurmont Fred; Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Martin		14. MOTHER'S MAIDEN NAME Katherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alvey R. Cook		Address Hagerstown Md. R # 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO (b) Carcinoma of the colon DUE TO (c) 153.58 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Indefinite 1 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 24 1960 to August 25 1960 , that (I) (we) last saw the deceased alive on August 24 60 and that death occurred at 9:38A. M, from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley, M.D.		22b. DATE SIGNED 8/26/60	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/28/60	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REG STRAR AUG 30 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION



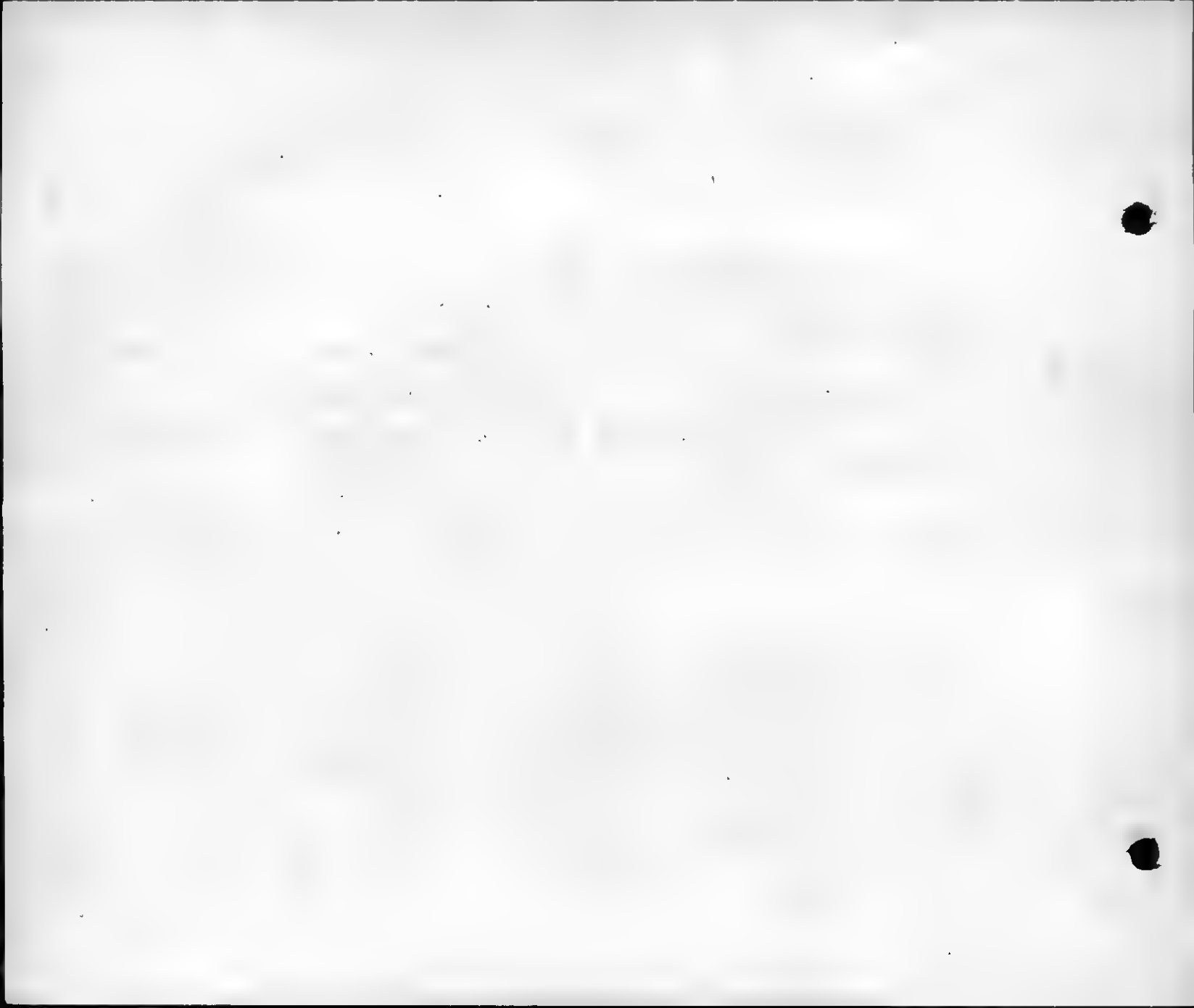
9661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1960

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUISE Middle BUTTERFIELD Last COWAN				4. DATE OF DEATH Month August Day 14 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1901		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Minneapolis, Minn	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Howard A. Butterfield				14. MOTHER'S MAIDEN NAME Gertrude Blake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 078-10-8712		17. INFORMANT Mr. Charles R. Cowan Box 151 R#2 Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of brain - Metastatic 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breasts DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Petit Mal - e.p.i. 12 yrs							INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 1960 to Aug 14, 1960 , that (I) (we) last saw the deceased alive on Aug 14, 1960 , and that death occurred at 6 AM , from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffman M.D.				22b. DATE SIGNED 8/15/60		22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman	
22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/17/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoms							

Wm. G. Horst



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certifi cate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

9662

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

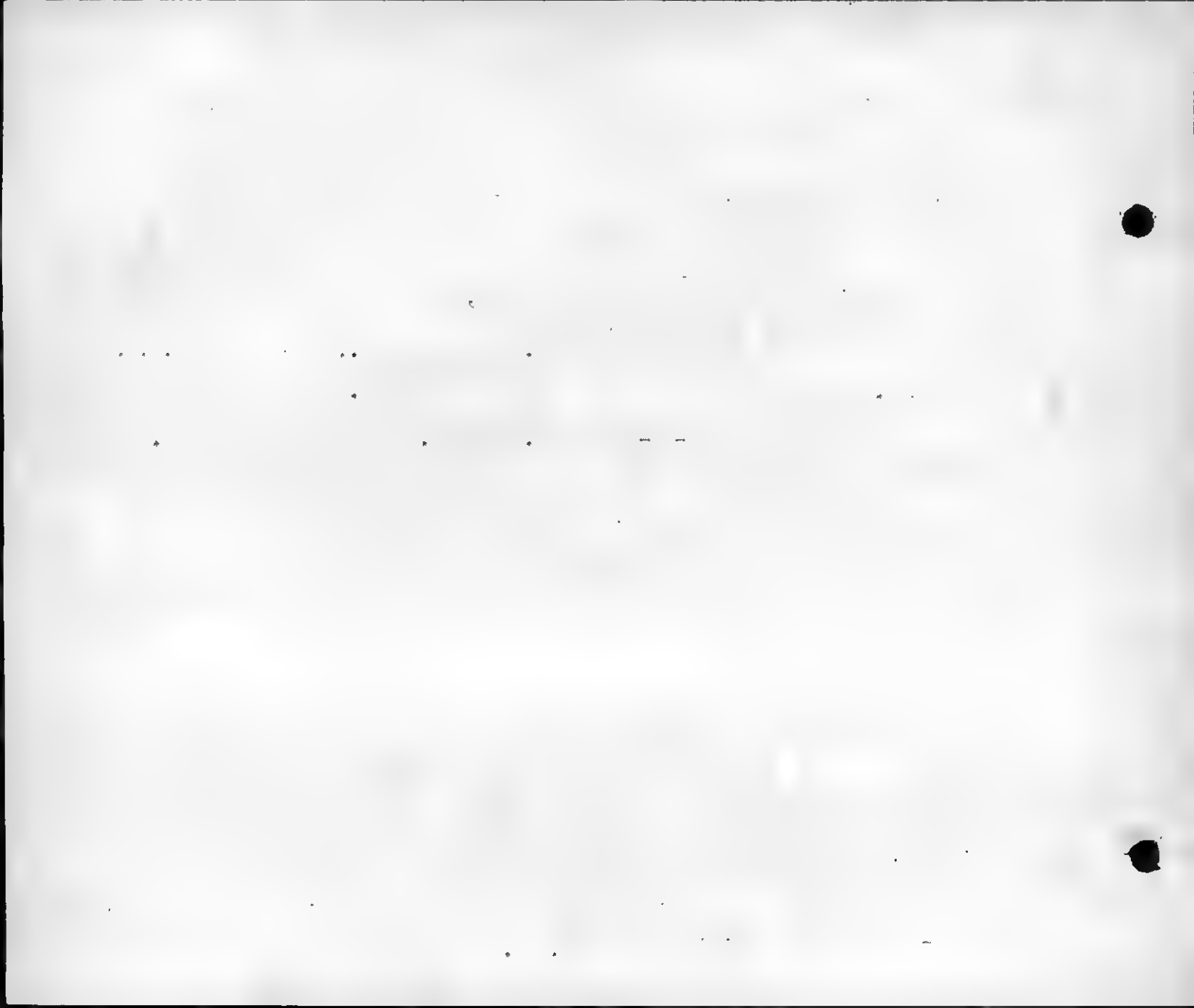
09642

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRY LEE DAY				4. DATE OF DEATH Month Day Year August 24 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1894	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Sand blasting & Dust cleaning Man.		11. BIRTHPLACE (State or foreign country) Frederick Co., Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James D. Day				14. MOTHER'S MAIDEN NAME Laura V. Spaulding			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-9864		17. INFORMANT Address Mrs. Mabel V. Day Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 Papillary carcinoma of the DUE TO (b) bladder with wide spread Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) metastasis							INTERVAL BETWEEN ONSET AND DEATH 4-6 Mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Apr 13, 1960 to Aug 24, 1960 , that (I) (we) last saw the deceased alive on Aug 24, 1960 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE Edward W. Ditt III, M.D.				22b. DATE SIGNED AUG 24 1960			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditt III, M.D.				22d. ADDRESS 217 W. Washington St. Hagerstown, Md.			
23a. BURIAL, CREMATON, REMOVA. (Specify) Burial		23b. DATE THEREOF 8/27/1960		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Burkittsville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Super - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 26 '60	
				25b. REGISTRAR'S SIGNATURE C. L. S. Kraw			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9663

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08643

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Western Md. Chronic Hosp</u>		d. STREET ADDRESS <u>128 W. ALL SAINTS</u>	
3. NAME OF DECEASED (Type or print) <u>Aaron</u> First <u>Dorsey</u> Middle <u>Dorsey</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22-1972</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick-Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17. INFORMANT <u>JAMES H. Edwards</u>		Address <u>Fred. Md. 108 Ice St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary lymphatic carcinomatosis</u> 155-1 DUE TO (b) <u>Carcinoma of gall bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>metastatic carcinoma of liver, generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 25, 1960</u> to <u>Aug 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 29, 1960</u> , and that death occurred at <u>6:44</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE SIGNED <u>Aug 31, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna Ave Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-31-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hope Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Fred. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Hicks</u>		25a. REC'D BY REGISTRAR <u>SEP 2 '60</u>	
ADDRESS <u>Frederick-Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9664

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09644

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 65 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAUDE M'ddle OLIVIA Last EICHELBERGER				4. DATE OF DEATH Month August Day 25 Year 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1880	
9. AGE (In years last birthday) 80 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rohrersville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Poffenberger			
14. MOTHER'S MAIDEN NAME Mildred Gant				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. Ruth Nokes Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion + 2u.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 min. 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, cerebral and generalized							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug. 23, 1960 to Aug. 25, 1960 that (I) (we) last saw the deceased alive on Aug. 25, 1960 , and that death occurred at 9:30 PM from the causes and on the date stated above.							
22a. SIGNATURE W. T. Layman, M.D.				22b. DATE SIGNED 8-27-60		22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.	
22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/1960		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouzer				25a. REC'D BY REGISTRAR AUG 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

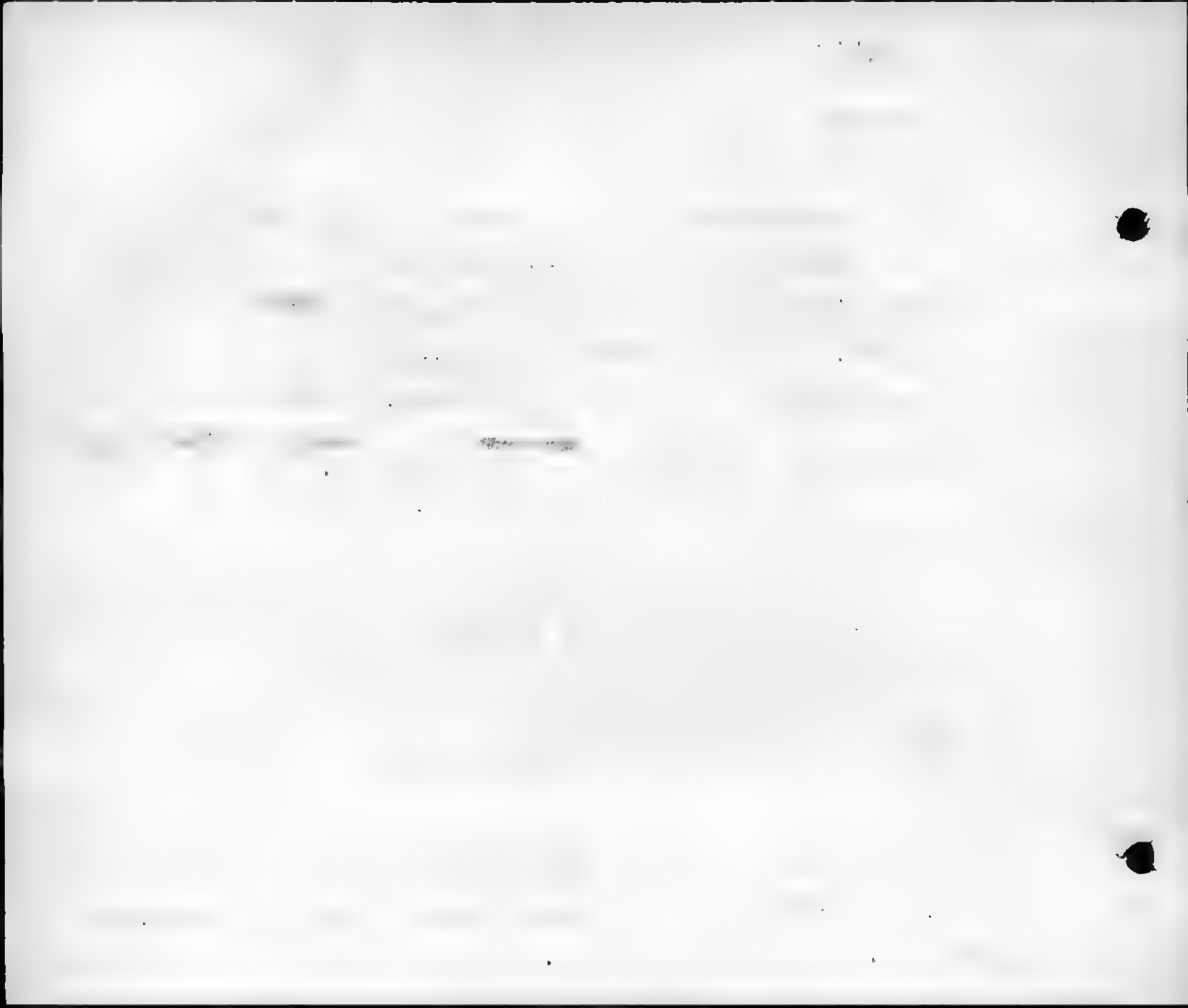
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9665

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09645

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 8 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1320 Ravenwood Hgts				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1320 Ravenwood Hgts e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HANNAH Middle (NMN) Last FLEISHER				4. DATE OF DEATH Month August Day 30 Year 1960			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jany 1 1866	
9. AGE (In years last birthday) 94 yrs.		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moses Brenner				14. MOTHER'S MAIDEN NAME Deborah (unable to locate)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none		17. INFORMANT Martin Fleisher 1320 n Ravenwood Hgts Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular D. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 30 1960 to Aug 30 1960 that (I) (we) last saw the deceased alive on Aug 30 1960 and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE Sidney Moverstein				22b. DATE SIGNED 8-30-60		22c. PHYSICIAN'S NAME (Type) SIDNEY MOVERSTEIN FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/60		23c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery Hagerstown Wash Co Md		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR SEP 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9666 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. ROUTE 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) ROBERT LEE FRALEY		4. DATE OF DEATH Month AUGUST Day 25 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 28, 1934
9. AGE (in years last birthday) 26		10. IF UNDER 1 YEAR Months 26 Days 13	11. IF UNDER 24 HRS. Hours 13 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY MARRIETTA TRUCKING	
11. BIRTHPLACE (State or foreign country) WAYNESBORO, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ROBERT FRALEY		14. MOTHER'S MAIDEN NAME KATHRYN POPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 217-30-6258	
17. INFORMANT MRS BETTY JUNE FRALEY		Address CLEAR SPRING, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractures Of Skull, Left Femur & Pelvis DUE TO 11 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Traumatic Diaphragmatic Hernia DUE TO (c) Laceration Of Spleen			INTERVAL BETWEEN ONSET AND DEATH 34 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) In collision with another car going in opposite direction.	
20c. TIME OF INJURY Month, Day, Year Hour 6:45 P M 8-23-1960	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Line Rd. Penna. Greencastle, Franklin, Pa.	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-26-60	
22a. BURIAL, CREMATON OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF AUG. 27, 1960	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		24a. REC'D BY REGISTRAR AUG 29 1960	24b. REGISTRAR'S SIGNATURE Arthur S. Kneale

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any death necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9667

CERTIFICATE OF DEATH

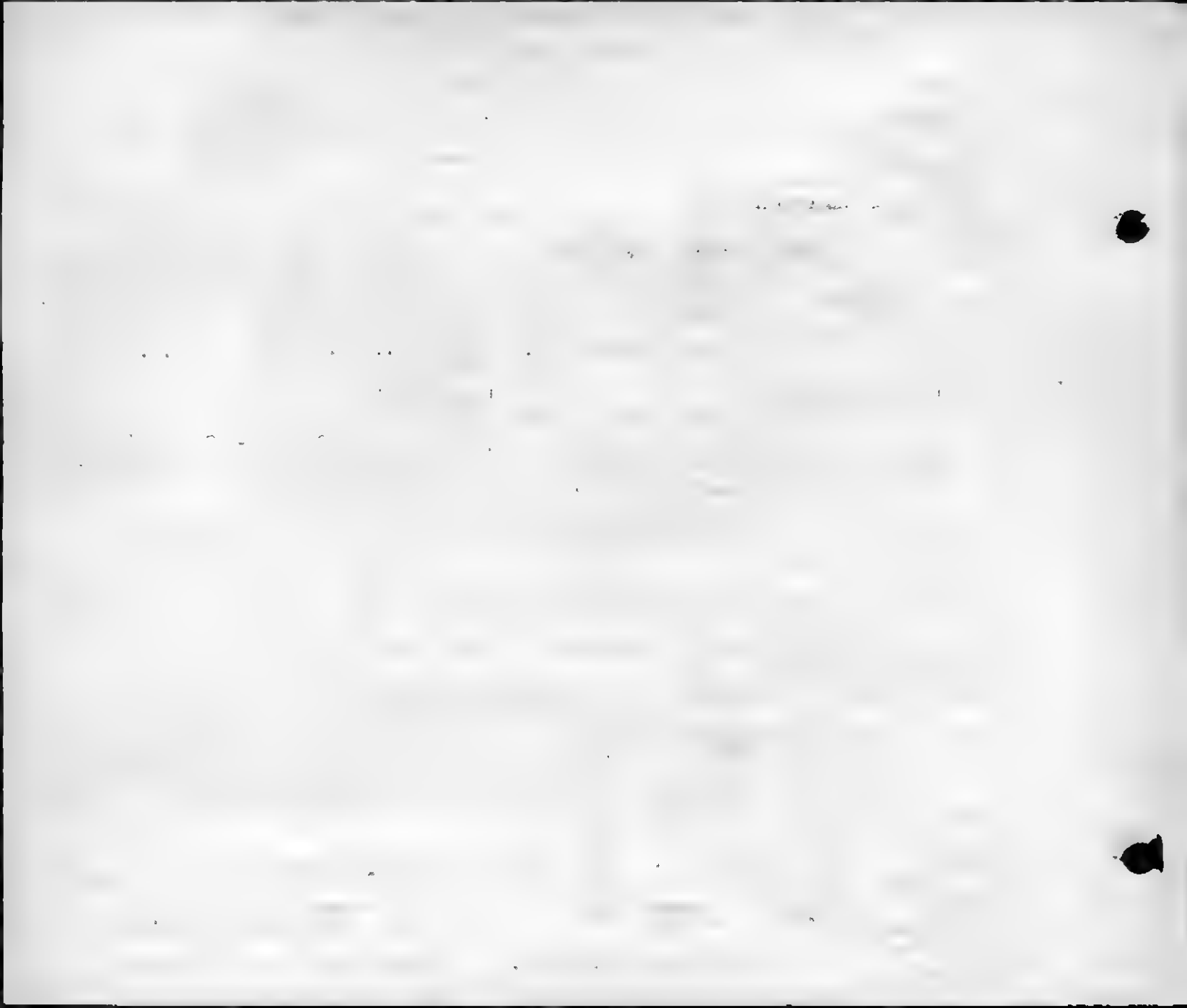
09647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna.		b. COUNTY Franklin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro		d. STREET ADDRESS 145 Ridge Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last George Clifford Freshman		4. DATE OF DEATH Month Day Year August 7 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1894		9. AGE (In years last birthday) yrs 65		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co.		11. BIRTHPLACE (State or foreign country) Fred. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES H. FRESHMAN		14. MOTHER'S MAIDEN NAME IDA MARTIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 173 03 0943							
17. INFORMANT MRS. GEORGE FRESHMAN - SAME ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of right lung with 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) extensive tumor metastasis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1960 , to August 7, 1960 , that I last saw the deceased alive on August 7, 1960 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.																					
ACTUAL SIGNATURE John H. Kehne M.D. ADDRESS (Street, city or town, state) Waynesboro, Penna. DATE SIGNED August 7, 1960																					
PHYSICIAN'S NAME (Type) John H. Kehne, M.D. 131 W. Washington St., Hagerstown, Md.																					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/60		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Penna.		23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Gore		ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR DATE AUG 11 '60		24b. REGISTRAR'S SIGNATURE Walter G. Gore							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

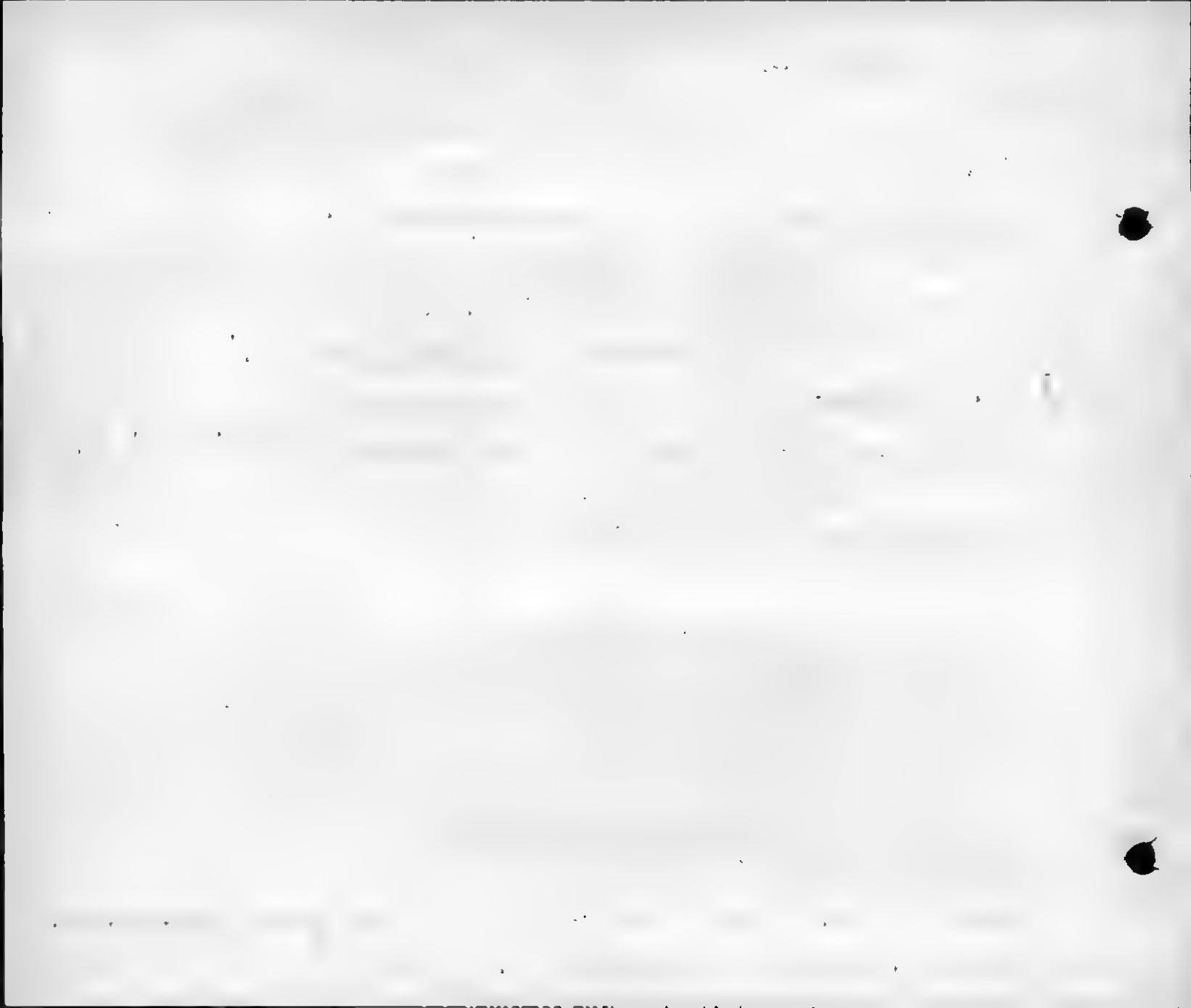
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9668

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09648

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH FUNK				4. DATE OF DEATH Month Day Year August 12 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feby. 4, 1879	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md. Keifer Allegany Co.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Keifer				14. MOTHER'S MAIDEN NAME Amaneda Ashkettle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Miss Lydia Funk		Address 43 E. Wash. St Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO Arteriosclerotic disease, cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Indefinite DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15-30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ateriosclerotic heart disease; obesity.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 10 a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to death , 19____, that (I) (we) last saw the deceased alive on January 11 1960 , and that death occurred at 2:45 PM from the causes and on the date stated above.							
22a. SIGNATURE Robert F. Keadle M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8-13-60	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle,				22d. ADDRESS Hagerstown, Maryland.			
23a. BJR AL. CREMAT. ON. REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur E. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

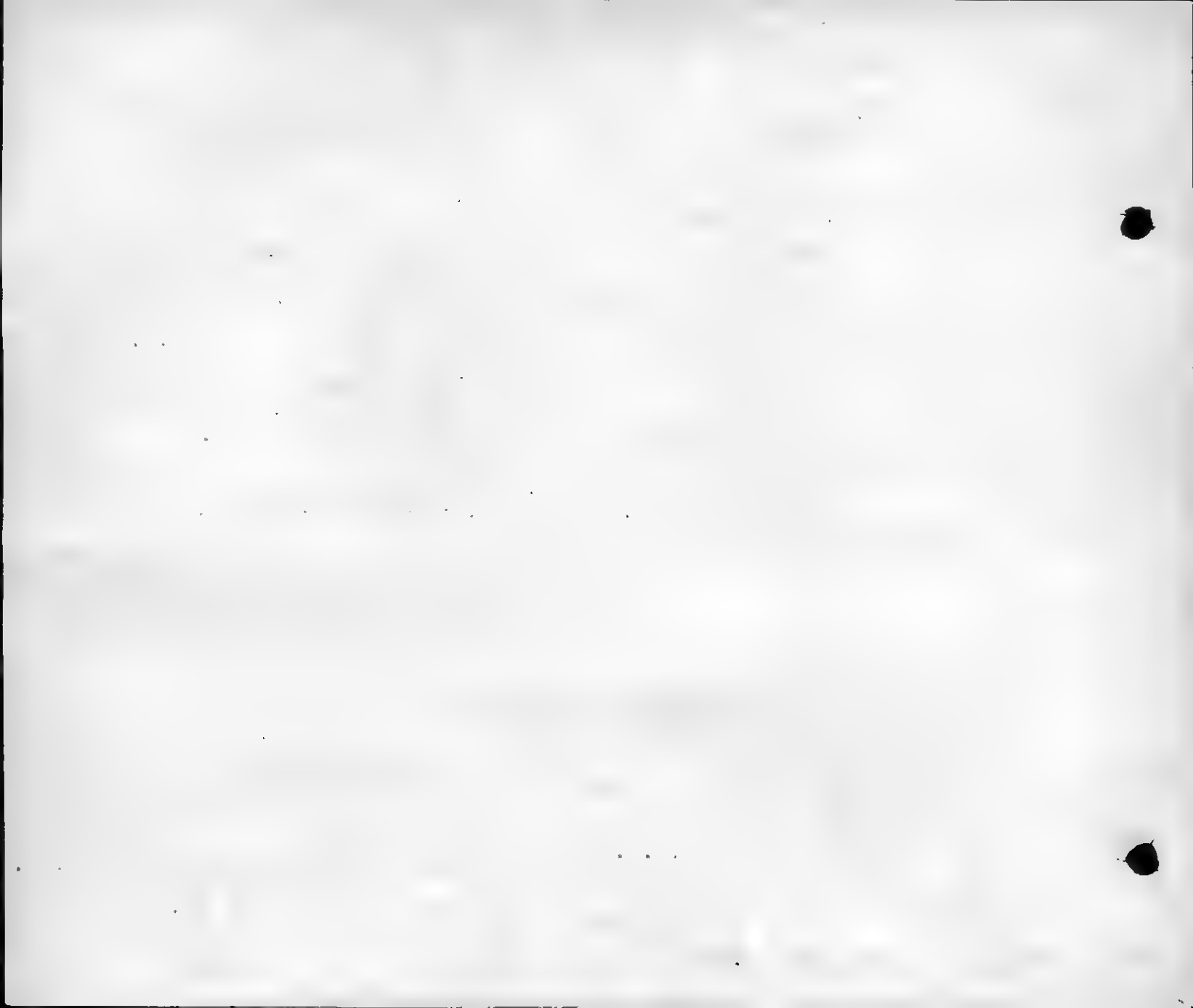
9719

09649

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) RURAL HAGERSTOWN				c. LENGTH OF STAY IN 1b 40 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) RT.#2 HAGERSTOWN				d. STREET ADDRESS RT.#2 HAGERSTOWN			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First DELIA Middle GOOD Last		4. DATE OF DEATH		Month AUGUST Day 28 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/22 / 1879		9 AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11 BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN F. ALESHIRE				14 MOTHER'S MAIDEN NAME BARBARA SOURS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. NONE		17 INFORMANT MRS. ETHEL RICE		Address RT.#6 HAGERSTOWN MD.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X circumcision of lung DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from 8/19/60 , 19____, to 8/28/60 , 19____, that (I) (we) last saw the deceased alive on 8/19/60 , 19____, and that death occurred at 3PM , from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/30/60			
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 North Potomac St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REPOSING (Specify) BURIAL		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY SALEM REFORMED CHURCH		23d. LOCATION (City, town, or county) WASHINGTON CO. MD. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.		ADDRESS _____		25a. REC'D BY REGISTRAR SEP 1 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9669

1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09650

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 3 weeks				d. STREET ADDRESS 639 Preston Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HENRI MARSHALL GROSS				4. DATE OF DEATH Month Day Year August 29 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8 1904	
9. AGE (in years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistics				10b. KIND OF BUSINESS OR INDUSTRY Pot-Edison Co			
11. BIRTHPLACE (State or foreign country) Jefferson Fred. Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
3. FATHER'S NAME Hammond H. Gross				14. MOTHER'S MAIDEN NAME Hattie Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 214-10-5301			
17. INFORMANT Mrs Helen M. Gross				Address 639 Preston Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO Carcinoma of the esophagus Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 13 mo. (c)				INTERVAL BETWEEN ONSET AND DEATH 2 mo.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on Aug 29, 1960 and that death occurred at 3:19 A.M. from the causes and on the date stated above.							
22a. SIGNATURE W. A. Hoffman M.D.				22b. DATE SIGNED 8/29/60			
22c. PHYSICIAN'S NAME (Type) W. A. Hoffman				22d. ADDRESS 214 N. Pot-st. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25. REC'D BY REGISTRAR DATE AUG 31 '60		25b. REGISTRAR'S SIGNATURE William S. Finner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

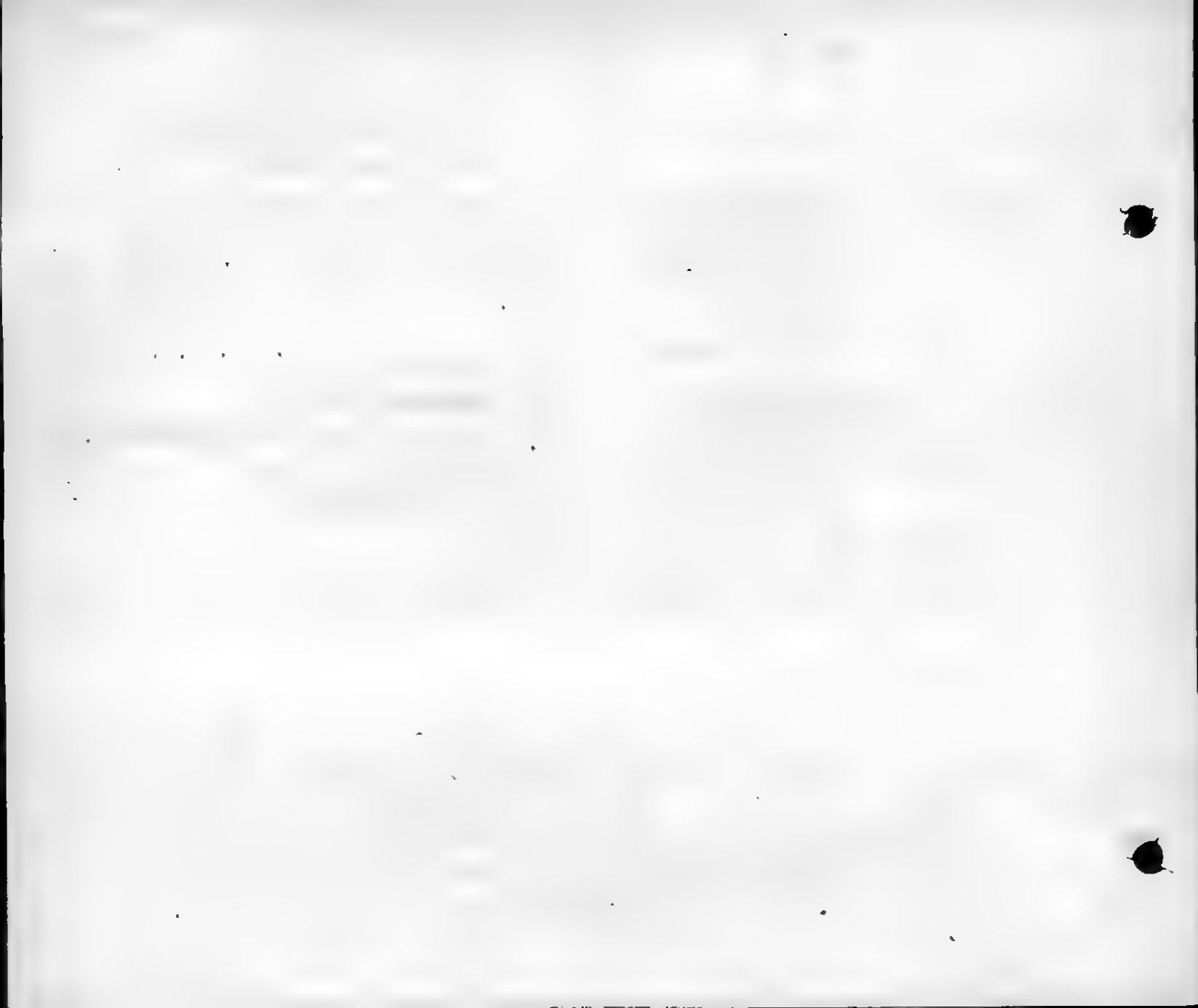
9670

09651

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring (Rural)</u>									
c. LENGTH OF STAY IN 1b <u>4 weeks</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Guessford</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>2</u> Year <u>19 60</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 9 1914</u>		9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>				11. BIRTHPLACE (State or foreign country) <u>Clearspring Dist. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Arthur Suffecool</u>						14. MOTHER'S MAIDEN NAME <u>Minerva Mills</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Mr. Lloyd Guessford</u> Address <u>Clearspring Md. RFD #1</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast metastatic</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>8/2/60</u> to <u>8/3/60</u> , that (I) (we) last saw the deceased alive on <u>8/2/60</u> , and that death occurred on <u>8/3/60</u> M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert Young</u>				22b. DATE SIGNED <u>8/3/60</u>				22c. PHYSICIAN'S NAME (Type) <u>Robert Young</u>					
22d. ADDRESS <u></u>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22f. ADDRESS <u></u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Clearspring Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leff</u> ADDRESS <u>Williamsport, Md</u>													
25a. REC'D BY REGISTRAR <u>Aug 8 '60</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>									

(M)

(I)



VR A15 (4)
15M 9/59

1. PLACE OF DEATH o. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL				d. STREET ADDRESS WILLIAMSBURG MD. R.I.			
3. NAME OF DECEASED (Type or print) First Middle Last WAYNE RICHARD HARKELL				4. DATE OF DEATH Month Day Year August 27 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 27, 1916	
9. AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months Days Hours Min. 2		IF UNDER 24 HRS 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HAGERSTOWN WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FLOYD HARKELL				14. MOTHER'S MAIDEN NAME ALICE J. JAMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address FLOYD HARKELL WILLIAMSBURG MD. R.I.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO Coronary Atherosclerosis (c) Coronary Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]					
20c. TIME OF INJURY Month Day Year Hour a m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/29/60 to 8/29/60 , that (I) (we) last saw the deceased alive on 8/29/60 , and that death occurred at 11 A.M. from the causes and on the date stated above							
22a. SIGNATURE Robert J. Jones				22b. DATE SIGNED SEP 6 1960			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF AUG. 31, 1960		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY HAGERSTOWN	
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. Jones				25a. REGISTERED DATE SEP 6 '60		25b. REGISTERED Arthur L. Jones	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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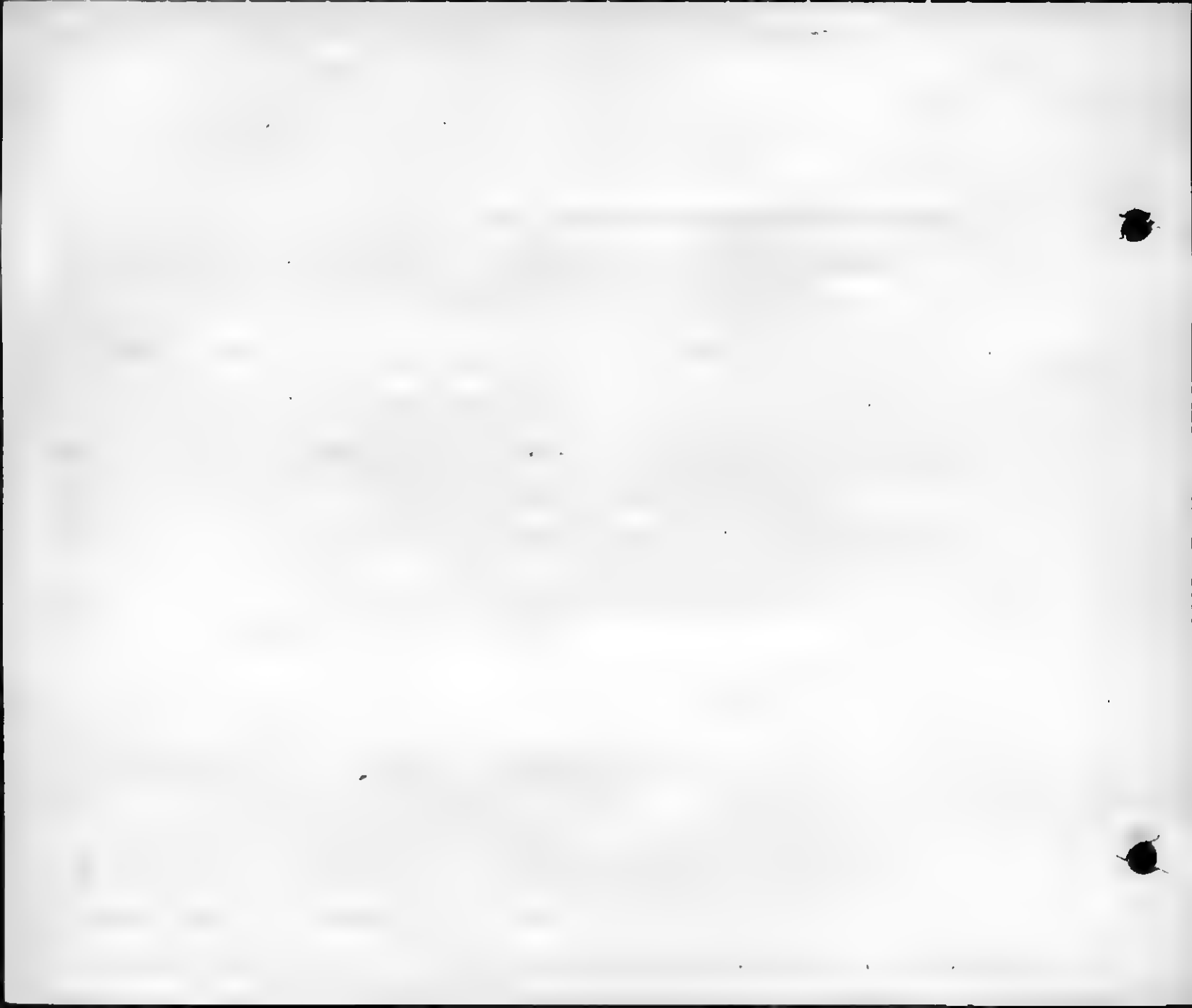
VR A15 (4)
ISM 9/59

9702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 302

09653

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro c. LENGTH OF STAY IN 1b 1 1/2 Mors d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Home for the Aging				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown d. STREET ADDRESS East Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) MOLLIE ELLEN HARSHMAN				4. DATE OF DEATH Month Day Year August 1, 1960 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1878 83 yrs. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wolfesville Fred Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Eccard				14. MOTHER'S MAIDEN NAME Charlotte Gaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. William Harshman, Chewsville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease 443X DUE TO (b) Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs 2 wks.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 25, 1960 , to Aug 1, 1960 , that (I) (we) last saw the deceased alive on July 31, 1960 , and that death occurred at 1 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE G. W. Hedera				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. W. Hedera				22d. ADDRESS Boonsboro Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/60		23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery		23d. LOCATION (City, town, or county) (State) Beaver Creek Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown Md				25a. REC'D BY REGISTRAR DATE AUG 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

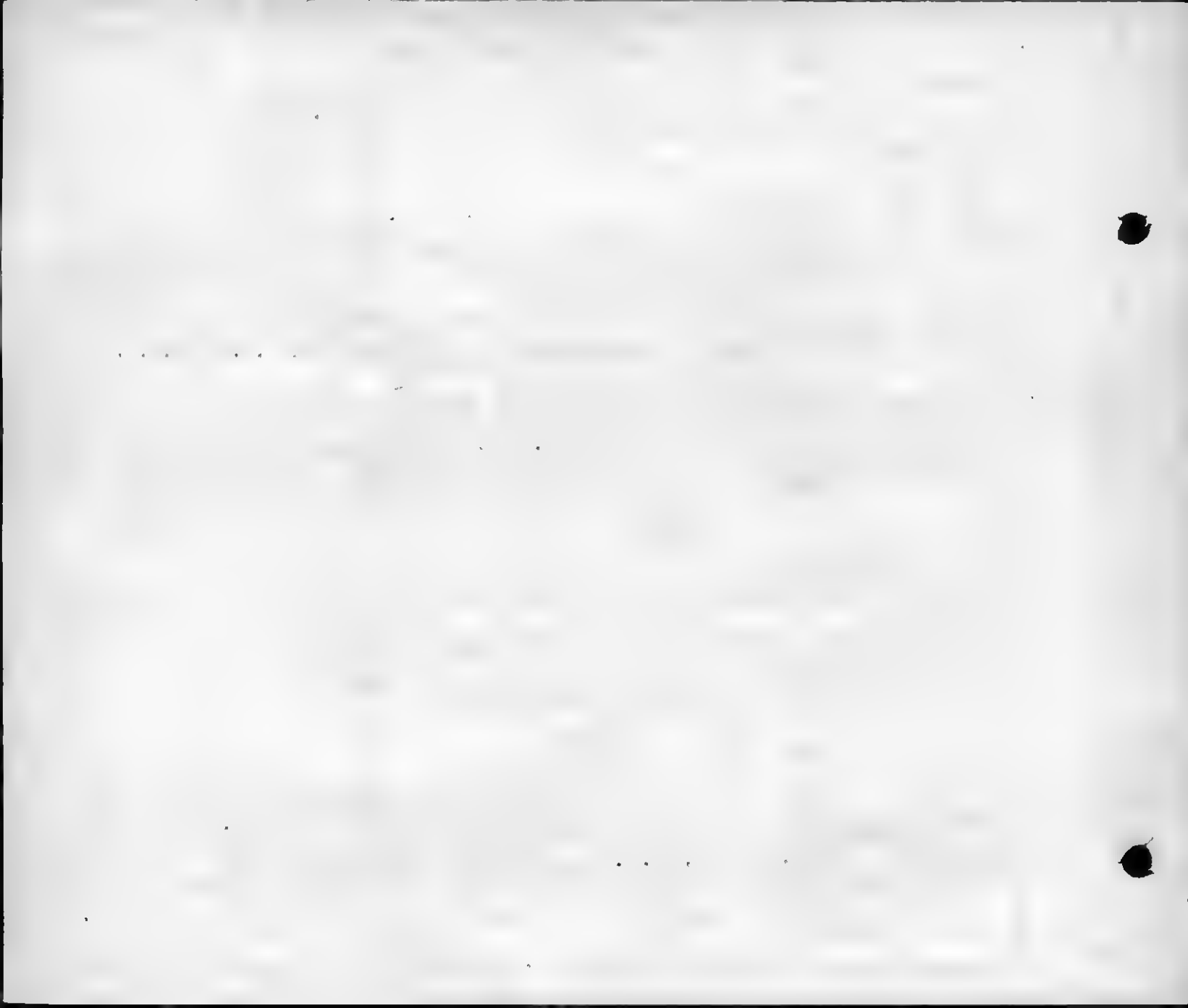
9672

CERTIFICATE OF DEATH

09654

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Maryland</u> Pa. b COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waynesboro</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>R.D. 4 Waynesboro, Pa.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Franklin Heefner</u>		4. DATE OF DEATH Month Day Year <u>August 22 1960</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1875</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete finisher & farmer</u>		9. AGE (In years last birthday) yrs. <u>85</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11 BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa. R.D. 5</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Heefner</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Benedict</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. H.M. Seydler</u>		Address <u>Huston Texas</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion & cirrhosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>six weeks</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/3/60</u> , 19 <u>60</u> , to <u>8/22/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/22/60</u> , 19 <u>60</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>136 North Potomac St. 8/22/60</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/24/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Grove</u>		ADDRESS <u>Waynesboro, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be turned in to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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9673
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302 09655

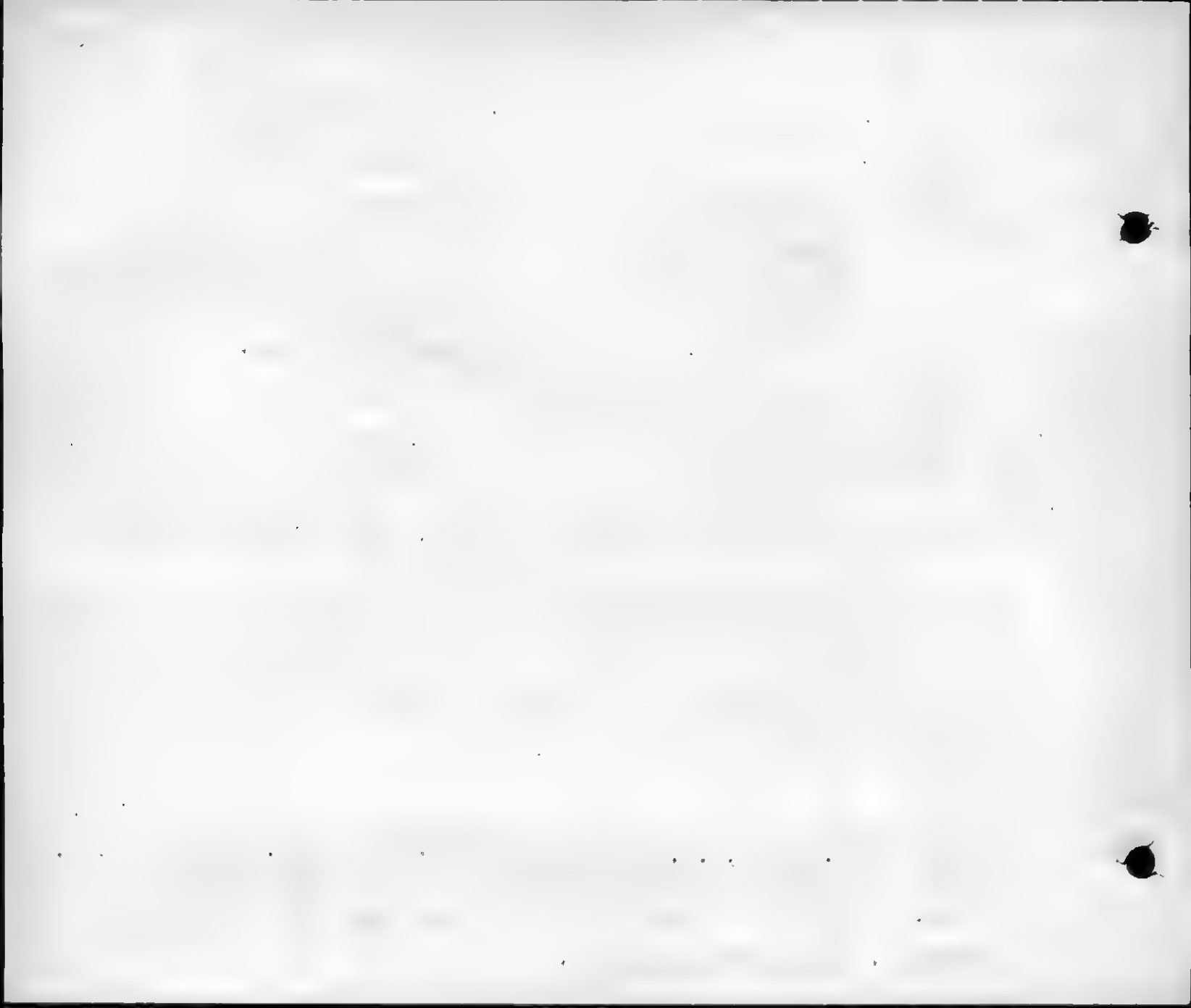
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle RILEY Last HOSE				4. DATE OF DEATH Month August Day 26 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23 1895		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY County Roads		11. BIRTHPLACE (State or foreign country) Rockdale Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Hose				14. MOTHER'S MAIDEN NAME Elizabeth Suman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-09-2411		17. INFORMANT Address Mrs Mary M. Miller Clearspring R# 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock 541-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured duodenal ulcer, peritonitis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis						19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/25/60 19____ to 8/26/60 19____, that (I) (we) last saw the deceased alive on 8/25/60 19____, and that death occurred at 5A M, from the causes and on the date stated above							
22a. SIGNATURE <i>Howard N. Weeks</i>				22b. DATE SIGNED 8/26/60		22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.	
22d. ADDRESS 136 N. Potomac St., Hagerstown, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/28/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR DATE AUG 30 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

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2

1

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

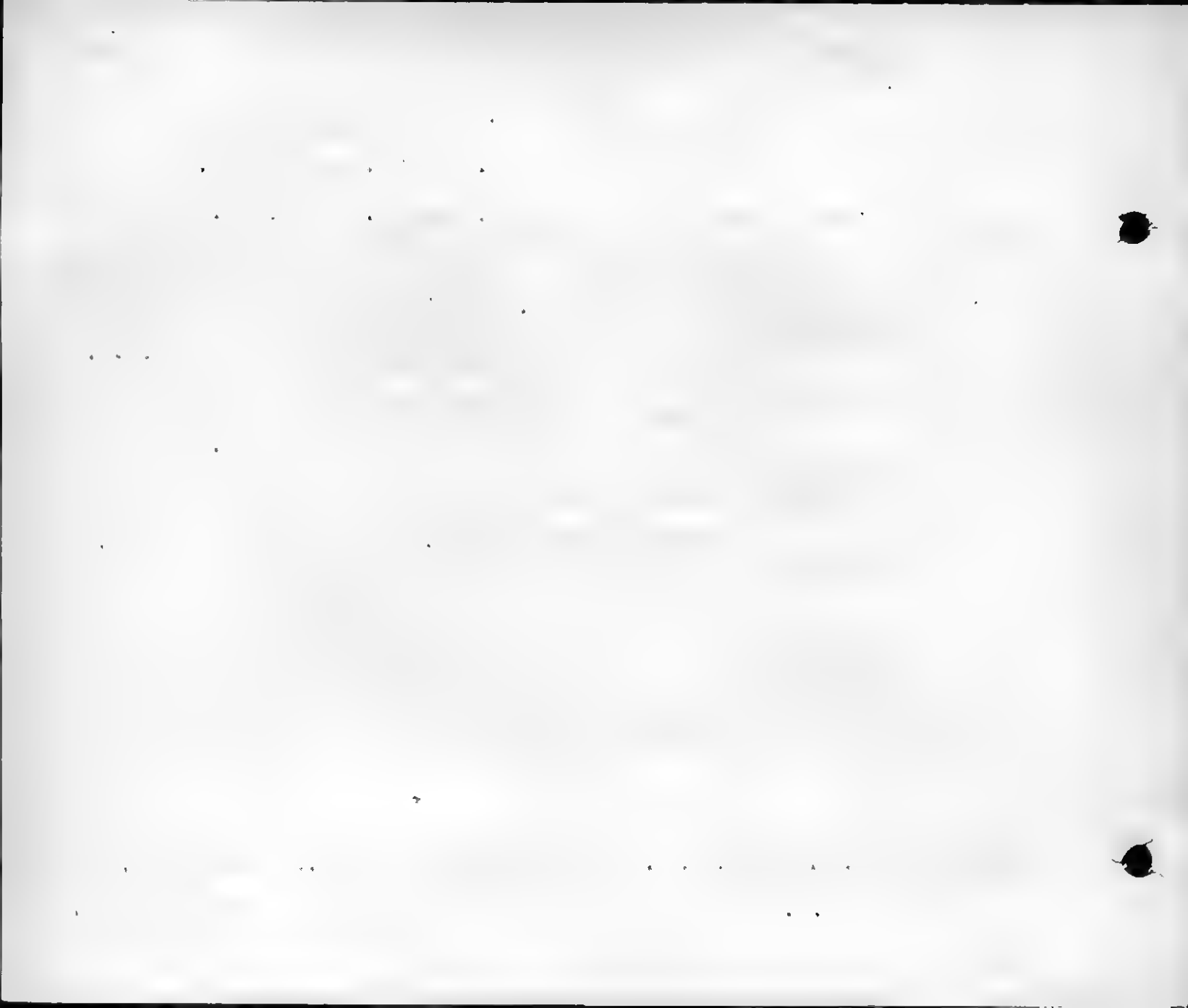
VR A15 (4)
15M 9/59

9720

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09656

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Main St. Hancock Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Nurseing Home</u>				d. STREET ADDRESS <u>W. Main St. Hancock Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matthew Hale Hughes</u>				4. DATE OF DEATH Month Day Year <u>8 5 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9.21.1877</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Hancock Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas T Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Mary J Bowhary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service,</u>		17. INFORMANT <u>Effie F Hughes Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>6 Mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>11/9/58</u> 19 <u> </u> to <u>8/5/</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/5/60</u> 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. G. Warden</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u>				22d. ADDRESS <u>832 Potomac Ave., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8.8.60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Thomas Episcopal</u>		23d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Glover Hancock Md</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR DATE <u>AUG 11 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							



may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9674
M
MAY 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09657

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>ONE WEEK</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>1236 POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE MAY HUTZELL</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 3 - 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 28 - 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BENEVOLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL W. FOLTZ</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA TOMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. PAUL LOUDENSLAGER BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>arterio-sclerosis generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-27-60</u> <u>7-17-60</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>July 27</u> 19 <u>60</u> to <u>Aug 3</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 3</u> 19 <u>60</u> and that death occurred at <u>4:10 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ludwig Nowenstein</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-5-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>S. B. WEY NOWENSTEIN</u>		22d. ADDRESS <u>Farmtown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>AUG. 7, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. West</u>		ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 10 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		



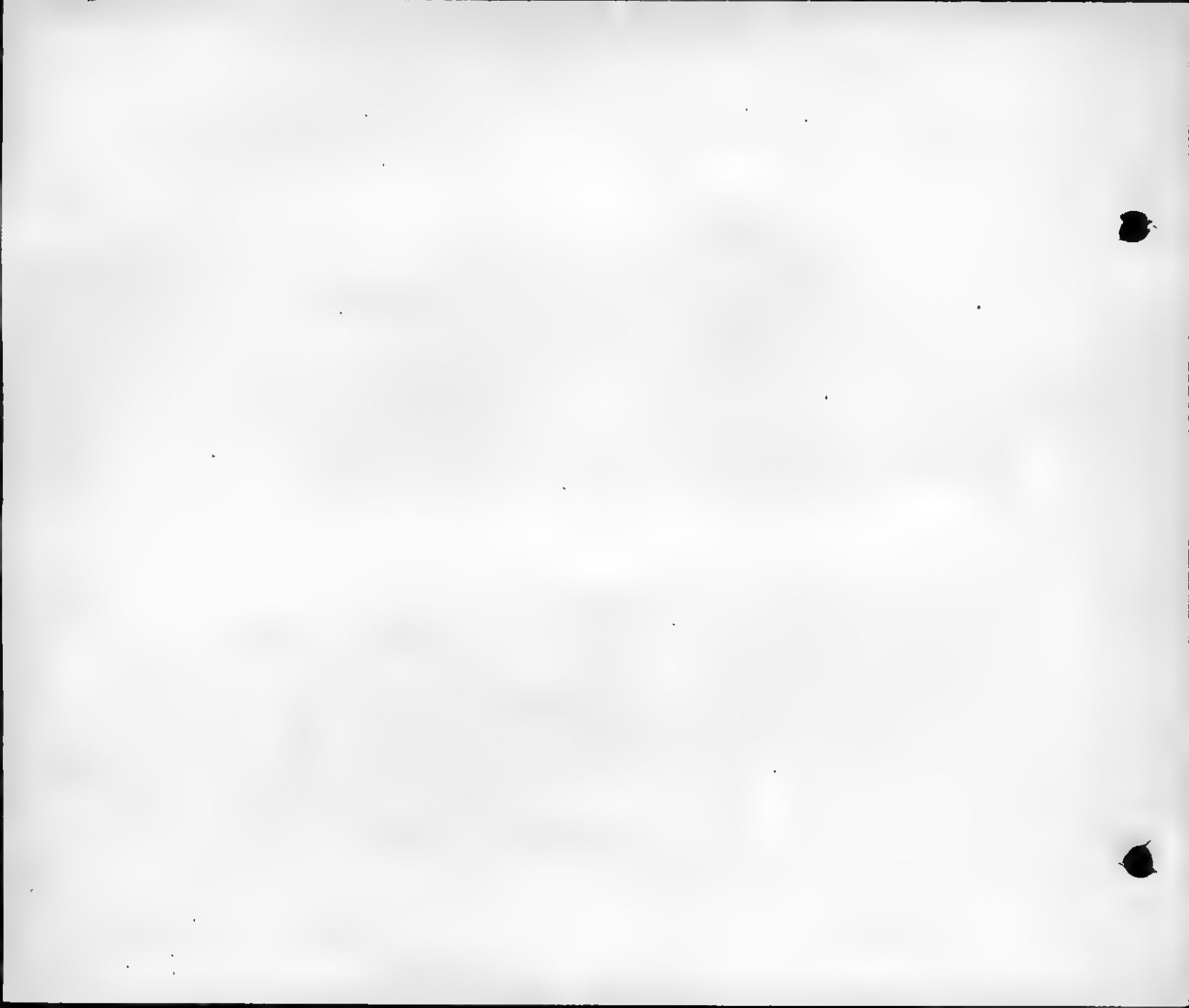
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09658

9703

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>1 yr</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTH MAIN ST.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>1 SOUTH MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM THOMAS ITNYRE</u>				4. DATE OF DEATH Month Day Year <u>August 27 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 15 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u>		11. IF UNDER 24 HRS. Hours <u>12</u> Min <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT-PRODUCE</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH CO MD U.S.A.</u>	
13. FATHER'S NAME <u>CHAS. D. ITNYRE</u>				14. MOTHER'S MAIDEN NAME <u>MARY SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>MRS. GRACE ITNYRE BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 15 1952</u> to <u>August 27 1960</u> that (I) (we) last saw the deceased alive on <u>August 27 1960</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Joseph Secondari</u> M.D.				22b. DATE SIGNED <u>8/22/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari</u>				22d. ADDRESS <u>21 North Main Street Boonsboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-30-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO C. METERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Helt</u>				25a. REC'D BY REGISTRAR <u>SEP 6 1960</u>		25b. REGISTRAR'S SIGNATURE <u>John H. Helt</u>	



9675

CERTIFICATE OF DEATH

09659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 29 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 710 W. WASHINGTON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle NEEDY Last JOHNSON		4. DATE OF DEATH Month AUGUST Day 16 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1909
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL & JIG WORKER		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CORP.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN F. JOHNSON	
14. MOTHER'S MAIDEN NAME CORA NEEDY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 217-10-3156		17. INFORMANT MRS. HELEN S. JOHNSON Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X Cerebral Reticular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 13 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-1-1959 to 8-16-1960 , that I last saw the deceased alive on 7-20-60 19 60 , and that death occurred at 6:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. E. Smith M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 9/17/60	
PHYSICIAN'S NAME (Type) M. E. W. Little			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/18/60	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR AUG 22 '60 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport- DOA Wash. Co. Hosp.				d. STREET ADDRESS 422 Faulkner Ave.			
3. NAME OF DECEASED (Type or print) First Linda Middle Lee Last Keedy				4. DATE OF DEATH Month August Day 30 Year 19 60			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Oct. 1942		9. AGE (in years last birthday) 17 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY Mtbg. High School		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard L. Keedy (Dec'd)				14. MOTHER'S MAIDEN NAME Lottie L. Koontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mtbg. W.Va. Mrs. Emery B. Ingram - 422 Faulkner Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) skull fracture, Basal fracture and broken neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Fall into stairwell DUE TO c) _____						INTERVAL BETWEEN ONSET AND DEATH immediately	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell into stairwell at Williamsport, Md.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 8/30/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CPE STREET		20f. (City or town) (County) (State) Williamsport Wash. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Howard N. Weeks</i>		ACTING CORONER M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/31/60	
EXAMINER'S NAME (Type) Howard N. Weeks, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2 Sept. 1960		22c. NAME OF CEMETERY OR CREMATORY Rosedale cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg, Berkeley, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE <i>(Signature)</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

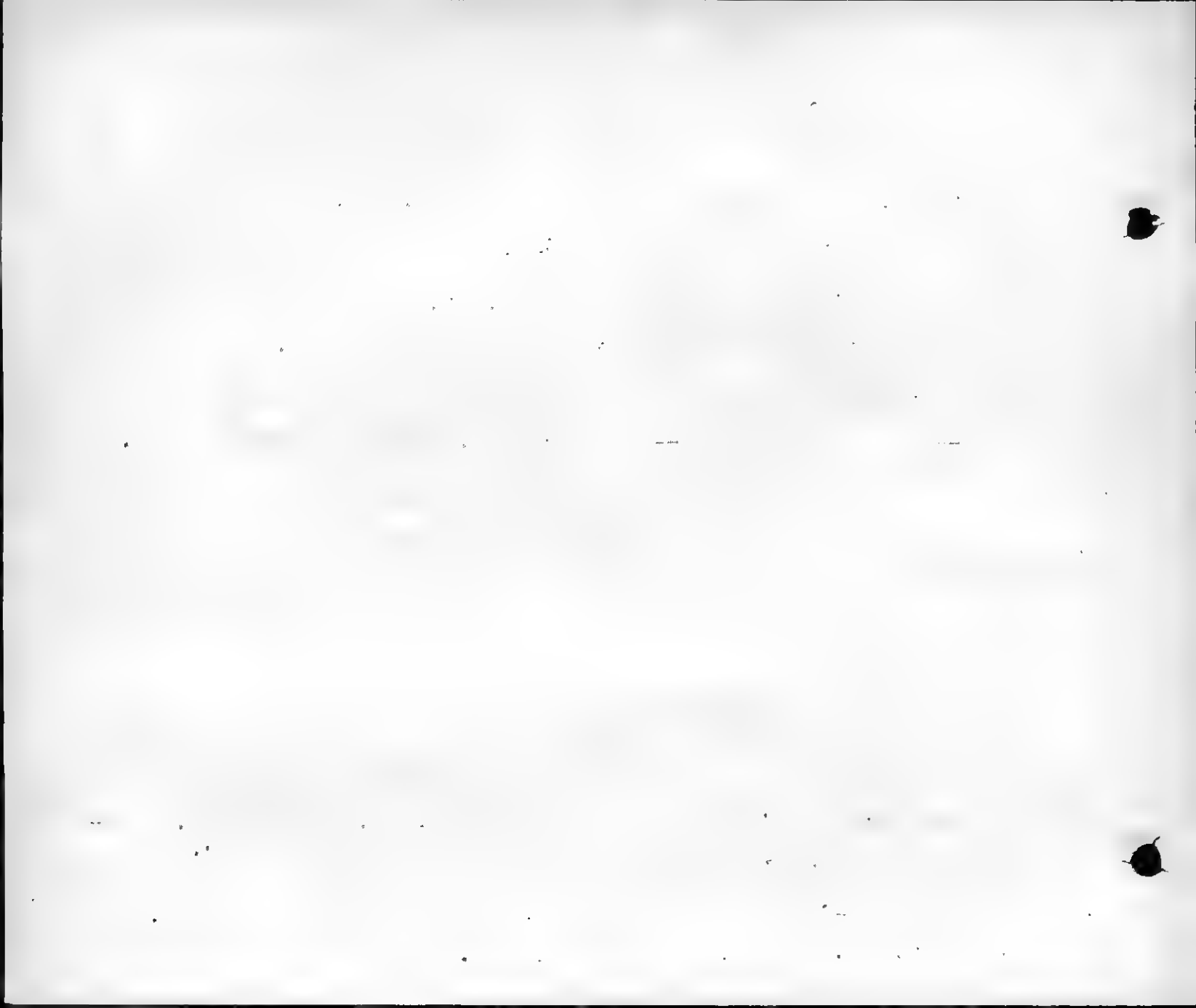
9676

CERTIFICATE OF DEATH

Reg. Dist. No.

09661

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>60</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>112 S. Prospect</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise</u> First <u>May</u> Middle <u>Kerney</u> Last				4. DATE OF DEATH <u>August</u> Month <u>24</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 26, 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
13. FATHER'S NAME <u>Silas Shifler</u>				14. MOTHER'S MAIDEN NAME <u>Estella Mc Dade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Elden L. Kerney</u>				Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u> </u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>August, 1957</u> to <u>Aug 24, 1960</u> that I last saw the deceased alive on <u>Aug 24, 1960</u> and that death occurred at <u>11:25 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Stauffer</u>				ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown Md.</u>			
PHYSICIAN'S NAME (Type) <u>John C. Stauffer</u>				DATE SIGNED <u>8-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown Md.</u>				22e. (State) <u> </u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Miller</u>				24c. (State) <u> </u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9677

CERTIFICATE OF DEATH

Reg. Dist. No.

09662

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>PENNSYLVANIA</u> b. COUNTY <u>FULTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRISONVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>NONE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE HENRY KING</u>				4. DATE OF DEATH Month Day Year <u>August 3 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11 1869</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>9 24</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>FULTON CO. PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM King</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN HENRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Name <u>Margaret K. Leiders</u> Address <u>McConnellsburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pylonephritis & uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Benign hypertrophy of prostate</u> DUE TO (c) <u>metastatic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7-1, 1960</u> , to <u>8-3-1960</u> , that I last saw the deceased alive on <u>8-3, 1960</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.				ADDRESS (Street, city or town, state) <u>124 W. Washington St - Hagerstown Md</u> DATE SIGNED <u>8-3-60</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER</u>				<u>Hagerstown - Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 6/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (Specify) <u>McConnellsburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Munnich & Son</u>				ADDRESS <u>Hagerstown Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				DATE REC'D BY REGISTRAR <u>AUG 8 '60</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
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VR A15 (4)
15M 9/59

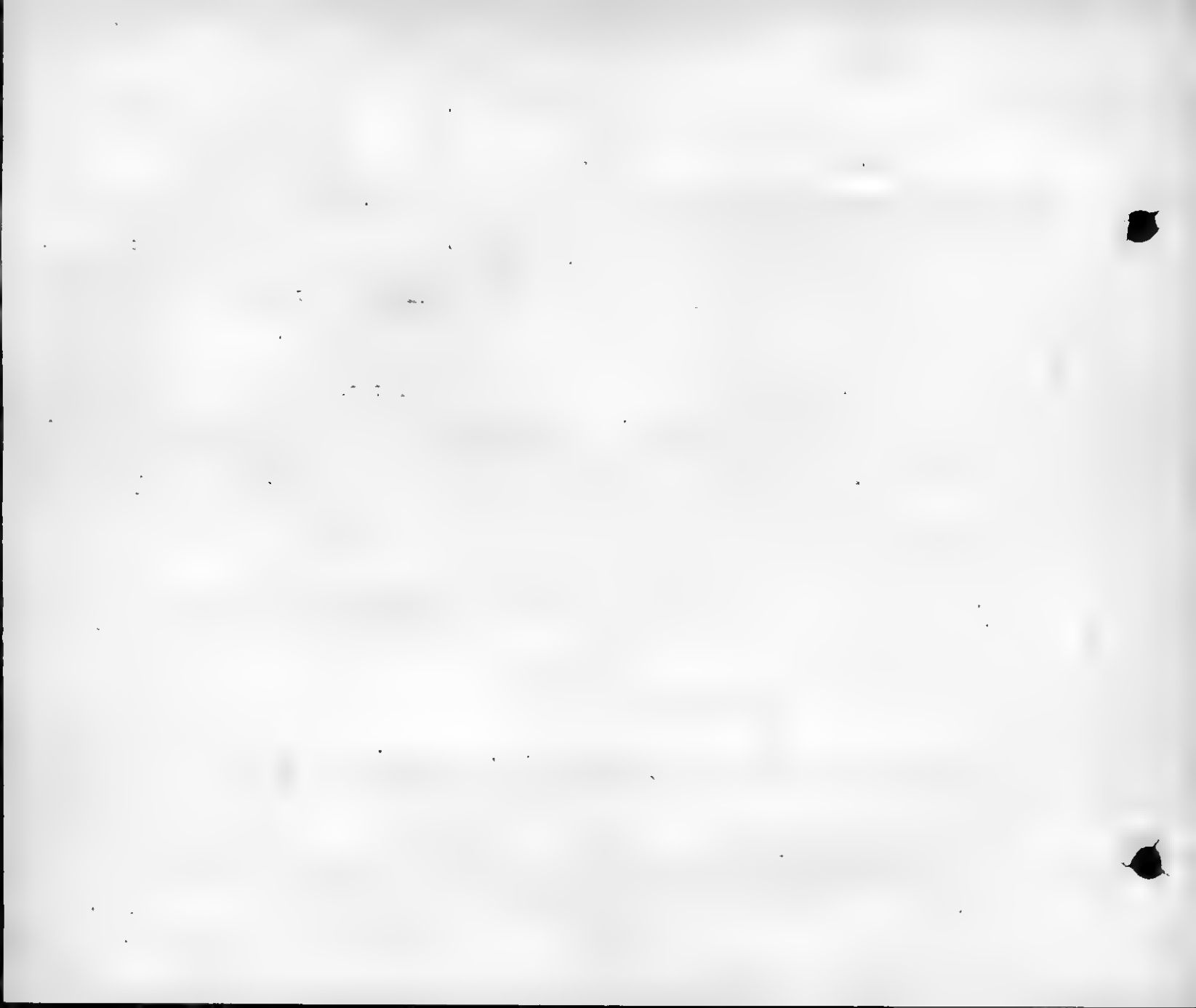
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9678

09663

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DALLAS Middle WALTER Last LEWIS		4. DATE OF DEATH Month 8 Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 April 19, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm & Misc.	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Daniel) Daniel Lewis		14. MOTHER'S MAIDEN NAME Maria Miskew Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Bruce Hudspeth		Address Hagerstown, Md. 25 E. Lincoln Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub-acute Pyelonephritis, Bi lateral DUE TO Hypertrophy of Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 years (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular pneumonia, Nephrolithiasis, Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1960 to Aug. 22, 1960 that (I) (we) last saw the deceased alive on Aug. 22, 1960 and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED Aug 22 1960	
22c. PHYSICIAN'S NAME (Type) Young E. Chun		22d. ADDRESS 1500 Penna Ave. Hagerstown, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/24/60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Church Cemetery		23d. LOCATION (City, town, or county) (State) Foxville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR AUG 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

Wm. A. Horst



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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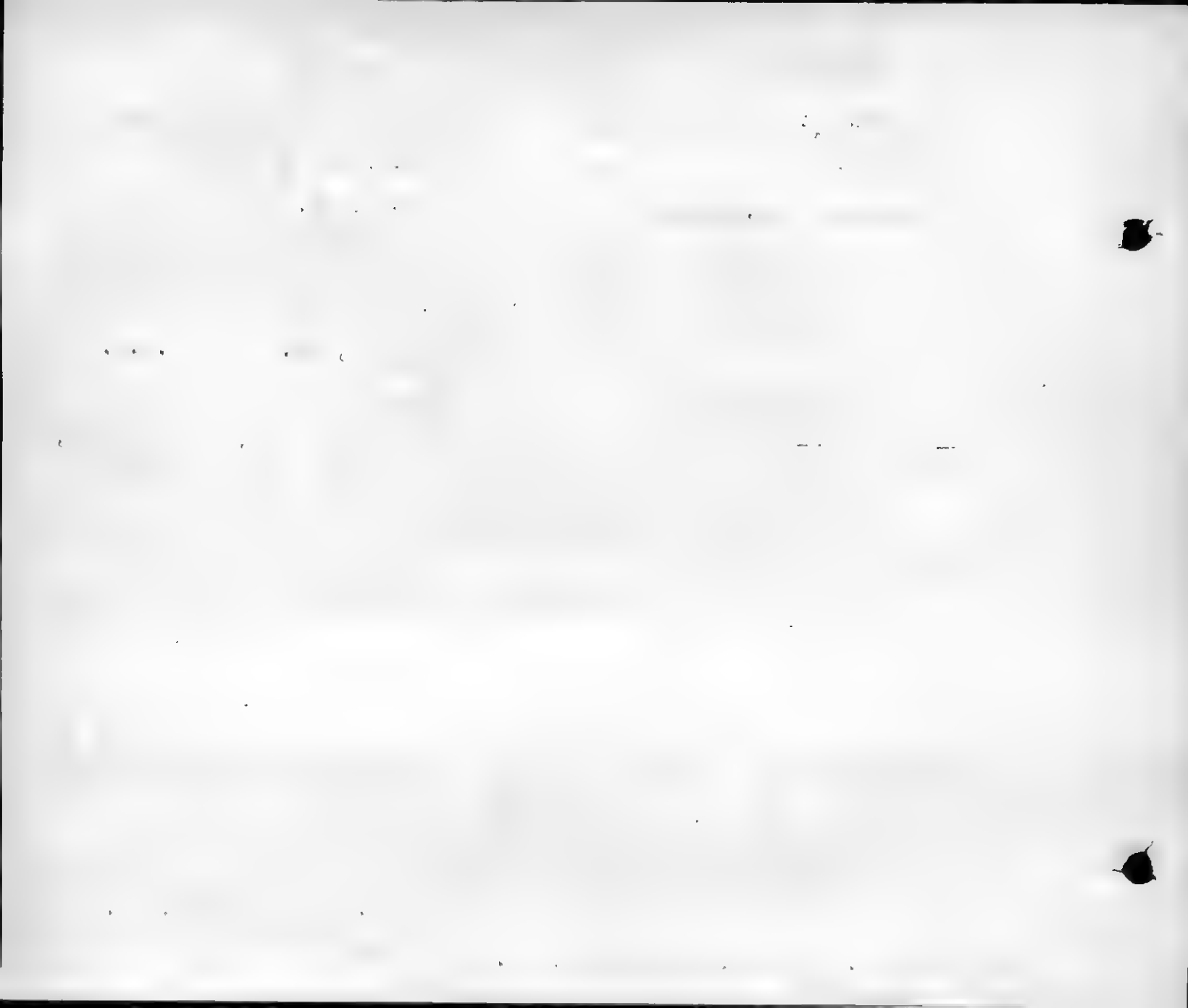
09664

302

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Cty. Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, R # 5 d. STREET ADDRESS Leitersburg, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hazel Middle Martha Last Lung				4. DATE OF DEATH Month August Day 14 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1890	
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Chewsville, Md.	
13. FATHER'S NAME Christian Paulsgrove				14. MOTHER'S MAIDEN NAME Anna Fry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Cleggett Lung, R # 5, Leitersburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Indefinite DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 11 p. m. 19		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to death , 19____, that (I) (we) last saw the deceased alive on August 13 1960 , and that death occurred at 8:45 A. from the causes and on the date stated above							
22a. SIGNATURE Robert F. Keadle				22b. DATE August 15, 1960		22c. PHYSICIAN'S NAME (Type) Robert F. Keadle	
22d. ADDRESS Hagerstown, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/16/60		23c. NAME OF CEMETERY OR CREMATORY Leitersburg Lutheran Cem., Leitersburg, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE AUG 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	



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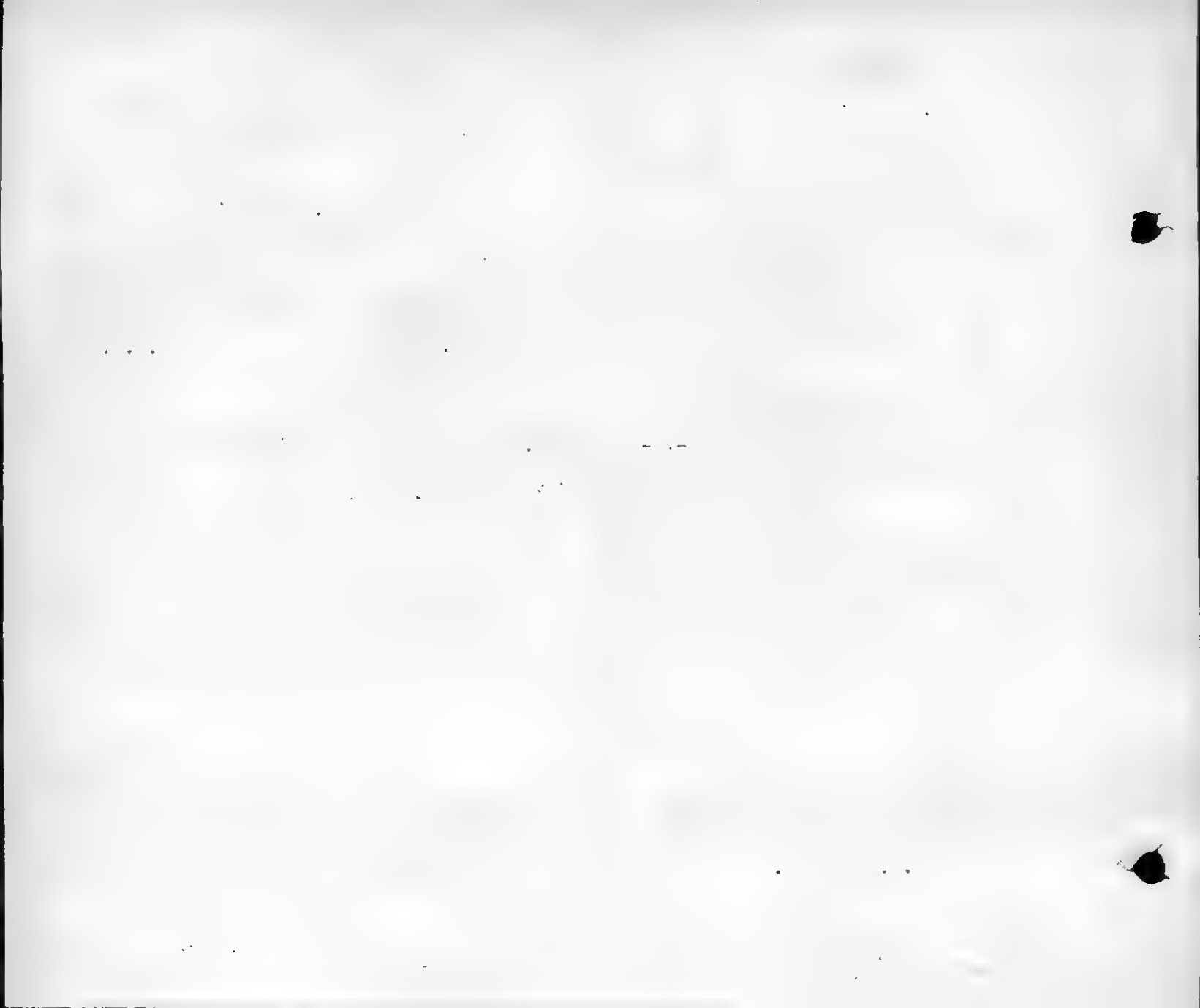
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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9680

09665

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 907 W WASHINGTON STREET		d. STREET ADDRESS 907 W WASHINGTON STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST RAPHAEL MARTIN		4. DATE OF DEATH Month Day Year AUG 18 '60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21 1898
9. AGE (In years lost birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 62 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MARTIN		14. MOTHER'S MAIDEN NAME MARY KENSEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-4999	
17. INFORMANT MRS. PEARL MARTIN		Address HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-7-1960 to 8-18-1960 , that (I) (we) last saw the deceased alive on 8-17-1960 , and that death occurred at 5 AM , from the causes and on the date stated above			
22a. SIGNATURE E.W. DITTO JR.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E.W. DITTO JR.		22d. ADDRESS HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/20/60	
23c. NAME OF CEMETERY OR CREMATORY BEST HAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Foye		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
25b. REGISTRAR'S SIGNATURE William S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

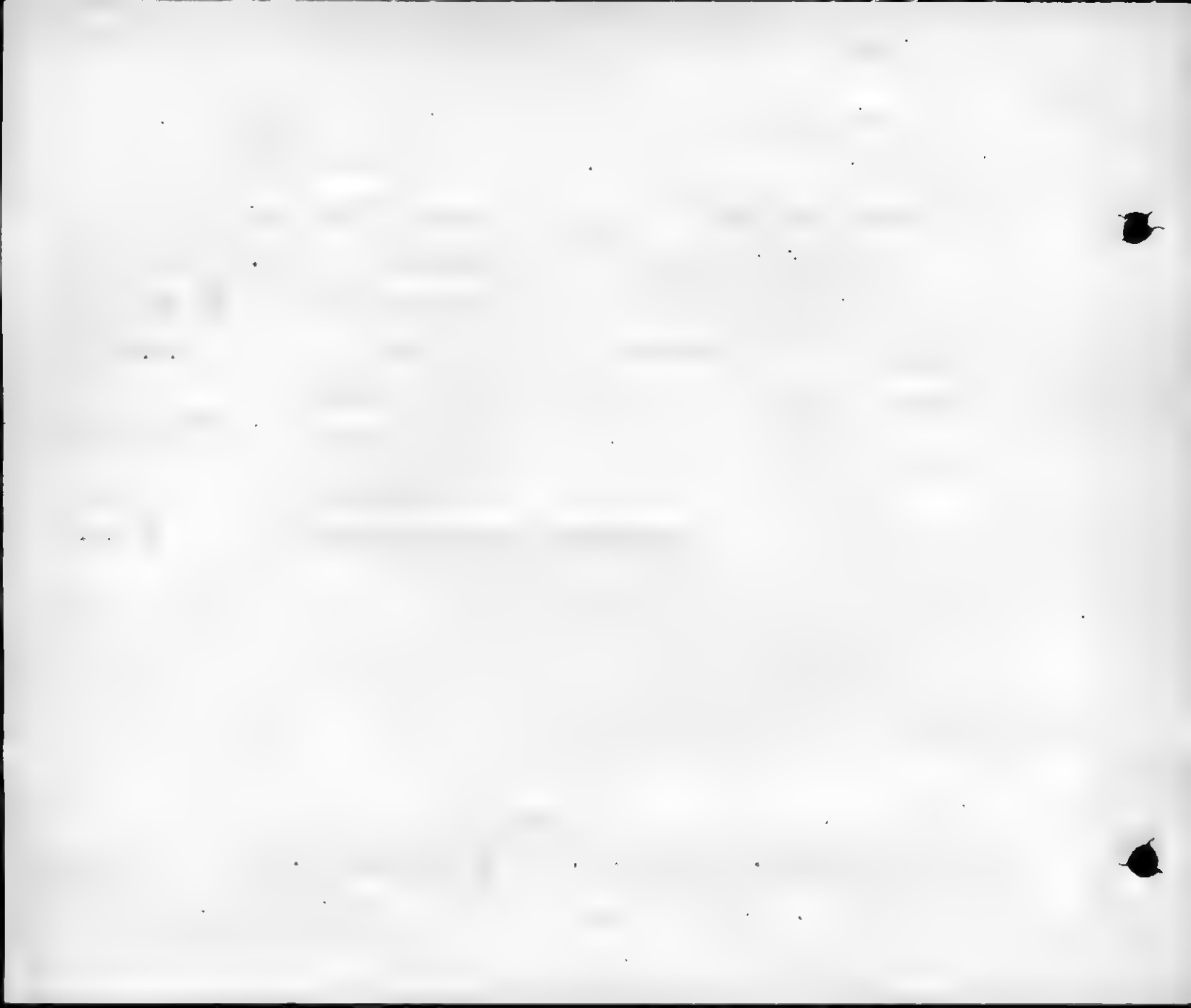
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9706

09666

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 44 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 Conococheague Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edmond Mc Cauley				4. DATE OF DEATH Month Day Year Aug. 27 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8 1884	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 4 18	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Tannery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Mc Gauley				14. MOTHER'S MAIDEN NAME Laura Stouffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 09 7412		17. INFORMANT 27dd Conococheague St. Md Mrs. Sarah Jane Mc Cauley Williamsport			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 34-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 1 Yr 5 Yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 8/27/60 , that (I) (we) last saw the deceased alive on 8/25/60 and that death occurred at 6A M, from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Shealy M. D.				22b. DATE SIGNED 8/28/60		22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29-60		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Maryland				25a. REC'D BY REG-STRAR DATE AUG 30 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

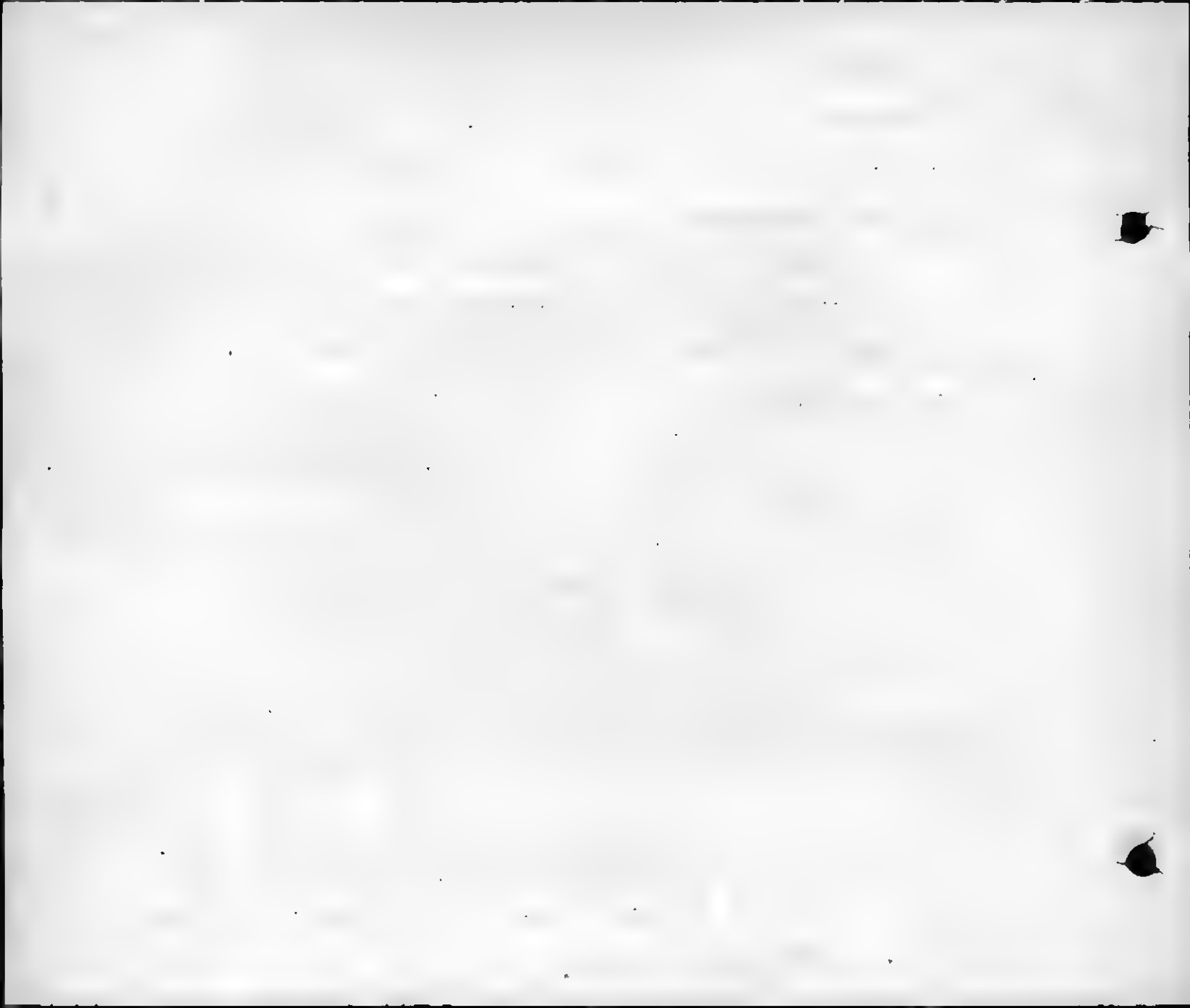
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

09667

9707

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 30 Randolph Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA (NMN) McCOY		4. DATE OF DEATH August 3 1960 Month August Day 3 Year 19	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1 1871 9. AGE (In years lost birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Love Dress Co	
11. BIRTHPLACE (State or foreign country) Funkstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arohibald McCoy		14. MOTHER'S MAIDEN NAME Martha Furry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unable to locate Mrs Mary Ellen Webb	
17. INFORMANT 18 E. Lincoln Ave Hagerstown Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 260X DUE TO (b) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Diabetes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 15 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1-60 to 8-3-60 that (I) (we) last saw the deceased alive on 8-1-60 and that death occurred on 8-3-60 M, from the causes and on the date stated above			
22a. SIGNATURE A. E. D. Coffman		22b. DATE 8/3/60	
22c. PHYSICIAN'S NAME (Type) Dr E W Dittus Jr		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/5/60	
23c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR AUG 5 '60	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

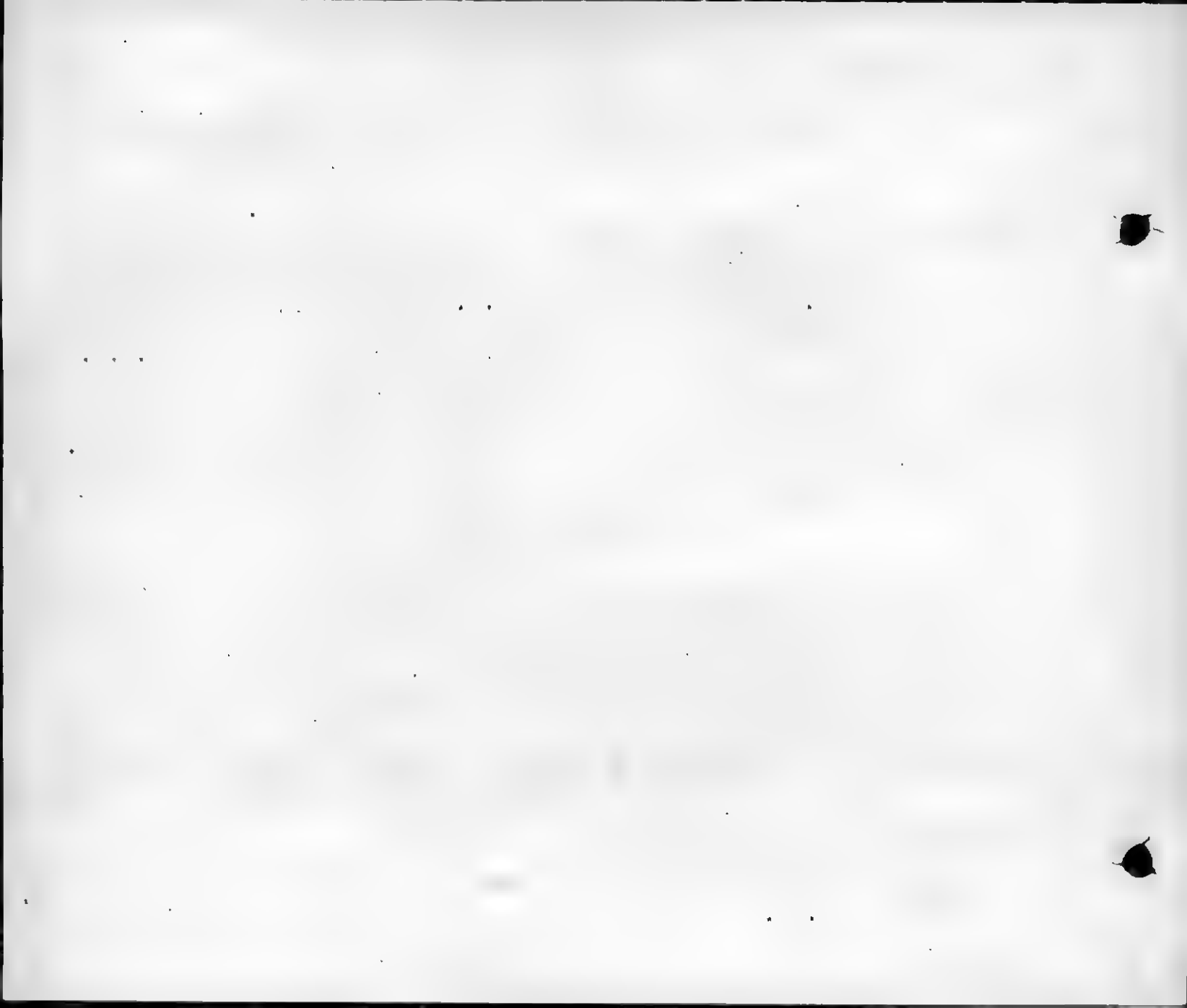
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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel Rebecca McCusker</u>				4. DATE OF DEATH Month Day Year <u>8 12 19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2. 1903</u>		9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hancock Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Munson</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert McCusker Rural 1 Hancock Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cereb of Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arterio sclerosis</u> DUE TO (c) <u>Cardio vasc. disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 1 1960</u> to <u>Aug 12 1960</u> that (I) (we) last saw the deceased alive on <u>Aug 12 1960</u> and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Shaffer</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L M SHAFFER MD</u>				22d. ADDRESS <u>Hancock Md</u>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8.15.60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Presbyterian</u>		23d. LOCATION (City, town, or county) (State) <u>Rural Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Houard J. Shaw</u>				25a. REC'D BY REGISTRAR <u>Hancock Md</u>		25b. REGISTRAR'S SIGNATURE <u>Celine J. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09669

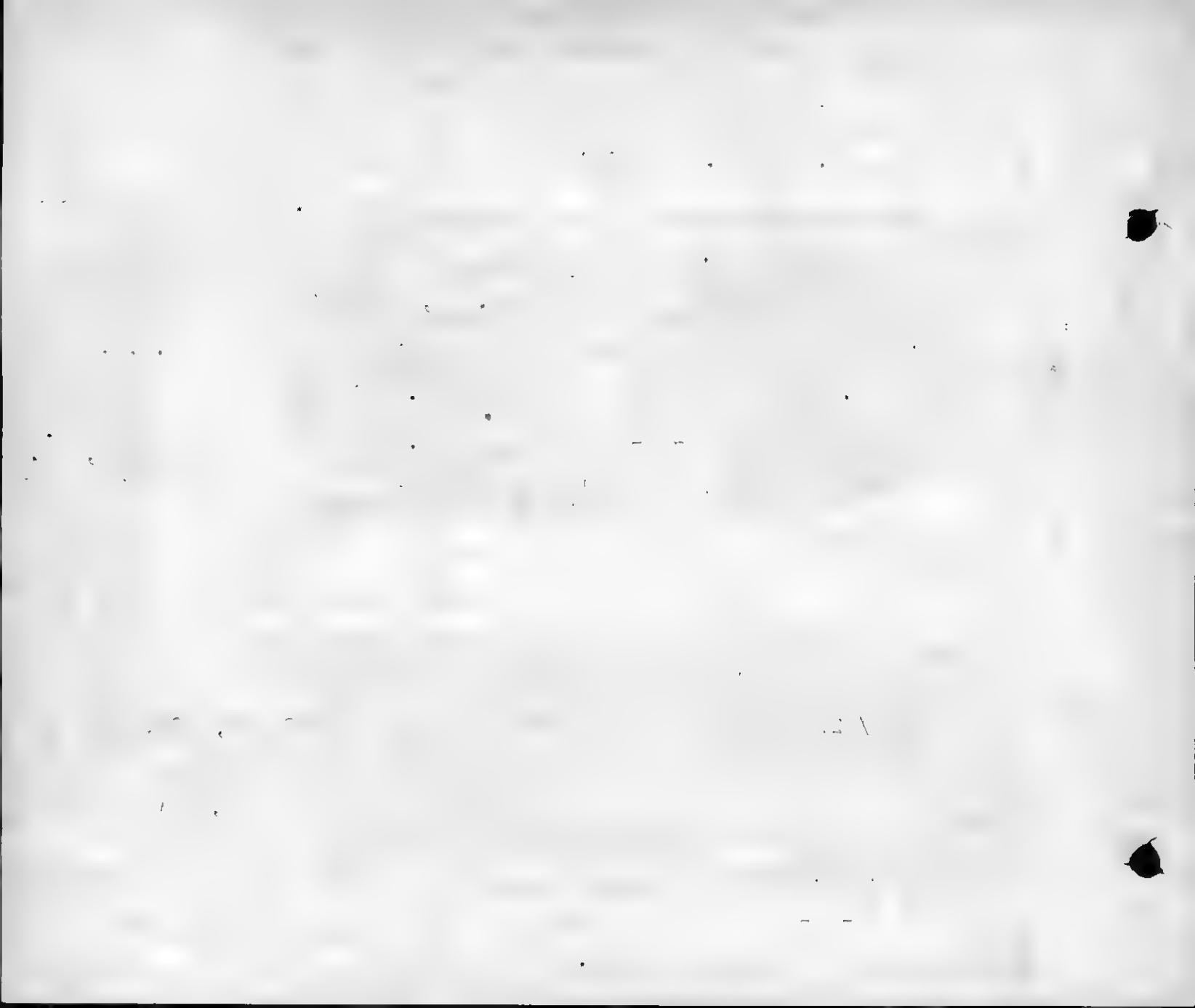
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kemps Mill nr. Hagers.</u> c. LENGTH OF STAY IN 1b <u>Indefinite</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>512 Salem Ave.</u> e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>E.</u> Last <u>Messner</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1927</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Messner</u>		14. MOTHER'S MAIDEN NAME <u>Lula B. Stitley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-20-3009</u>	
17. INFORMANT <u>Charles E. Messner</u>		Address <u>512 Salem Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK FOLLOWING HEMORRHAGE FROM SELF INFLICTED KNIFE WOUNDS</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTENSIONAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SUICIDE BY SLASHING BOTH WRISTS & NECK</u>	
20c. TIME OF INJURY Month, Day, Year <u>8/12/60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>KEMP MILL RD.</u>		20f. (City or town) <u>HAGERSTOWN, WASH. MD</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>DR. F. W. DITTO, JR.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. F. W. DITTO, JR.</u>		DATE SIGNED <u>AUG. 14, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>		22d. LOCATION (City, town, or county) <u>Thurmont, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		24a. REC'D BY REGISTRAR <u>AUG 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. ADDRESS <u>Thurmont, Md.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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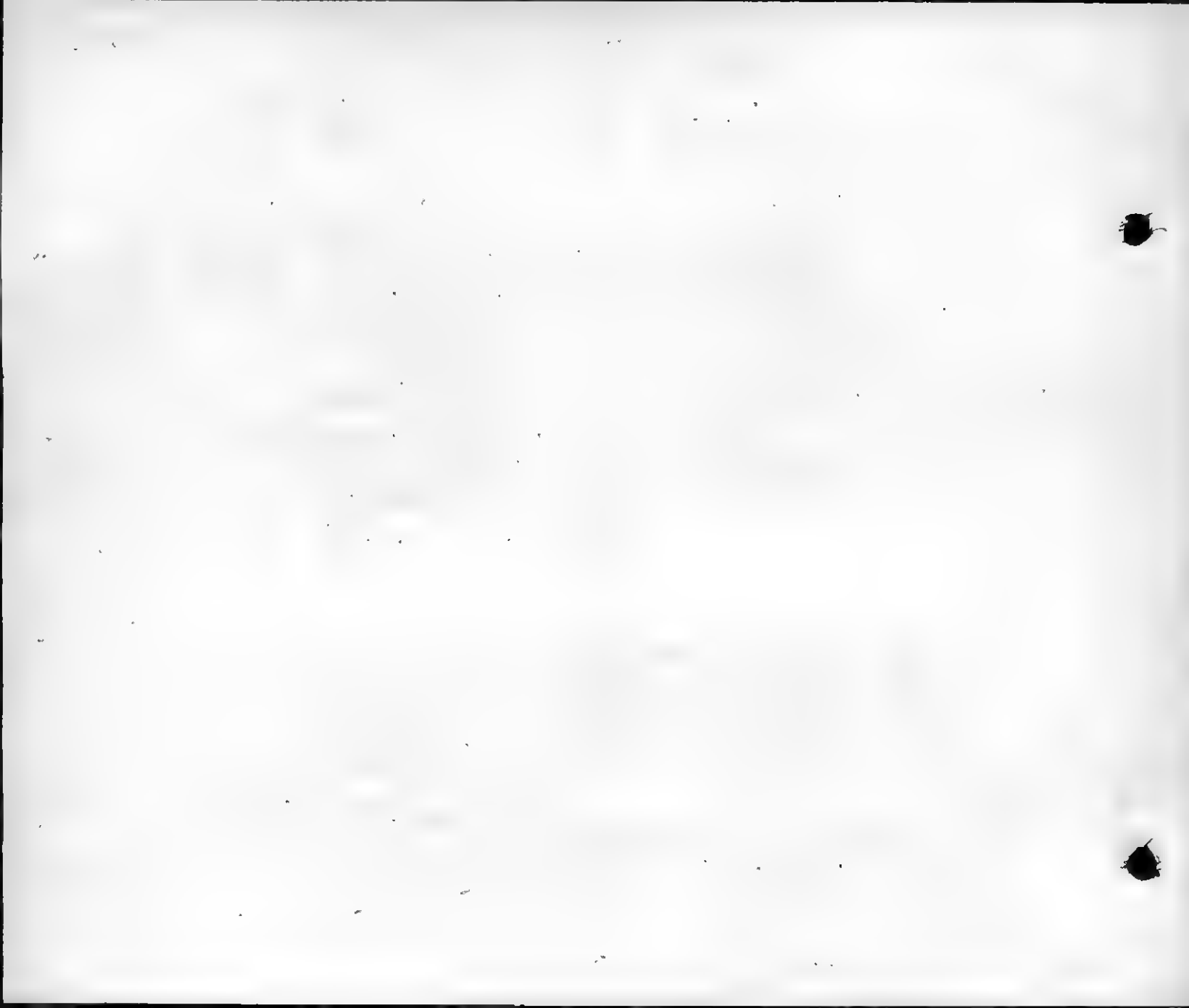
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9682

CERTIFICATE OF DEATH

09671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Rural</u> <u>Smithsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1 R.D.2</u>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>E.</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 21, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Edgemont, Md.</u>			
13. FATHER'S NAME <u>Abram Weddle</u>				14. MOTHER'S MAIDEN NAME <u>Alice E. Stouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Clarence Frey Smithsburg, Md. R.D.2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pancreatic</u> DUE TO (c) <u>Choliliathisis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-24</u> , 19 <u>59</u> , to <u>3-7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>60</u> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Smithsburg, Maryland</u> DATE SIGNED <u>3-8-60</u>							
ACTUAL SIGNATURE <u>Charles F. Hess</u> M D		PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u> <u>Smithsburg, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welty's</u>			
22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md. R.D.2</u>		24a. REC'D BY REGISTRAR <u>Walter Z. Hore</u> <u>Waynesboro, Pa.</u> DATE <u>AUG 11 '60</u>					
24b. REGISTRAR'S SIGNATURE <u>Walter Z. Hore</u>		24c. REGISTRAR'S SIGNATURE <u>Walter Z. Hore</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9683

302

09672

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS ELWOOD MILLER Sr				4. DATE OF DEATH Month Day Year August 30 1960 19			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17 1913		9. AGE (In years lost birthday) yrs. 47	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Miller				14. MOTHER'S MAIDEN NAME Annie V. Gantt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-6601		17. INFORMANT Mrs Ramona Miller 631 W. Franklin St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hagerstown Md. DUE TO (c) Interval between onset and death							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/30/60 19____, that (I) (we) last saw the deceased alive on 8/30/60 19____, and that death occurred at 11 M. from the causes and on the date stated above.							
22a. SIGNATURE Ralph F. Young				22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8/31/60	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young				22d. ADDRESS Williamsport Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/2/60		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Sleepy Creek Morgan Co W. Va	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR DATE SEP 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House	

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9684

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09673

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1924 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Tilghmanton Last Moats		4. DATE OF DEATH Month Aug. Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10 1877
9. AGE (in years last birthday) 83		10. IF UNDER 1 YEAR Months 6 Days 3	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Organ Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME Harry Moats		14. MOTHER'S MAIDEN NAME Susan Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219 12 0507	
17. INFORMANT Gardner Moats		18. ADDRESS 1924 Virginia Ave. Hagerstown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO CC. myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/3/60 to 8/14/60 that (I) (we) last saw the deceased alive on 8/19/60 and that death occurred at 11 AM from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 8/16/60	
22c. PHYSICIAN'S NAME (Type) RALPH F. YOUNG		22d. ADDRESS Williamsport, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 17-60	
23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town, or county) (State) Near Tilghmanton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		25a. REC'D BY REGISTRAR AUG 18 '60	
		25b. REGISTRAR'S SIGNATURE O. L. S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

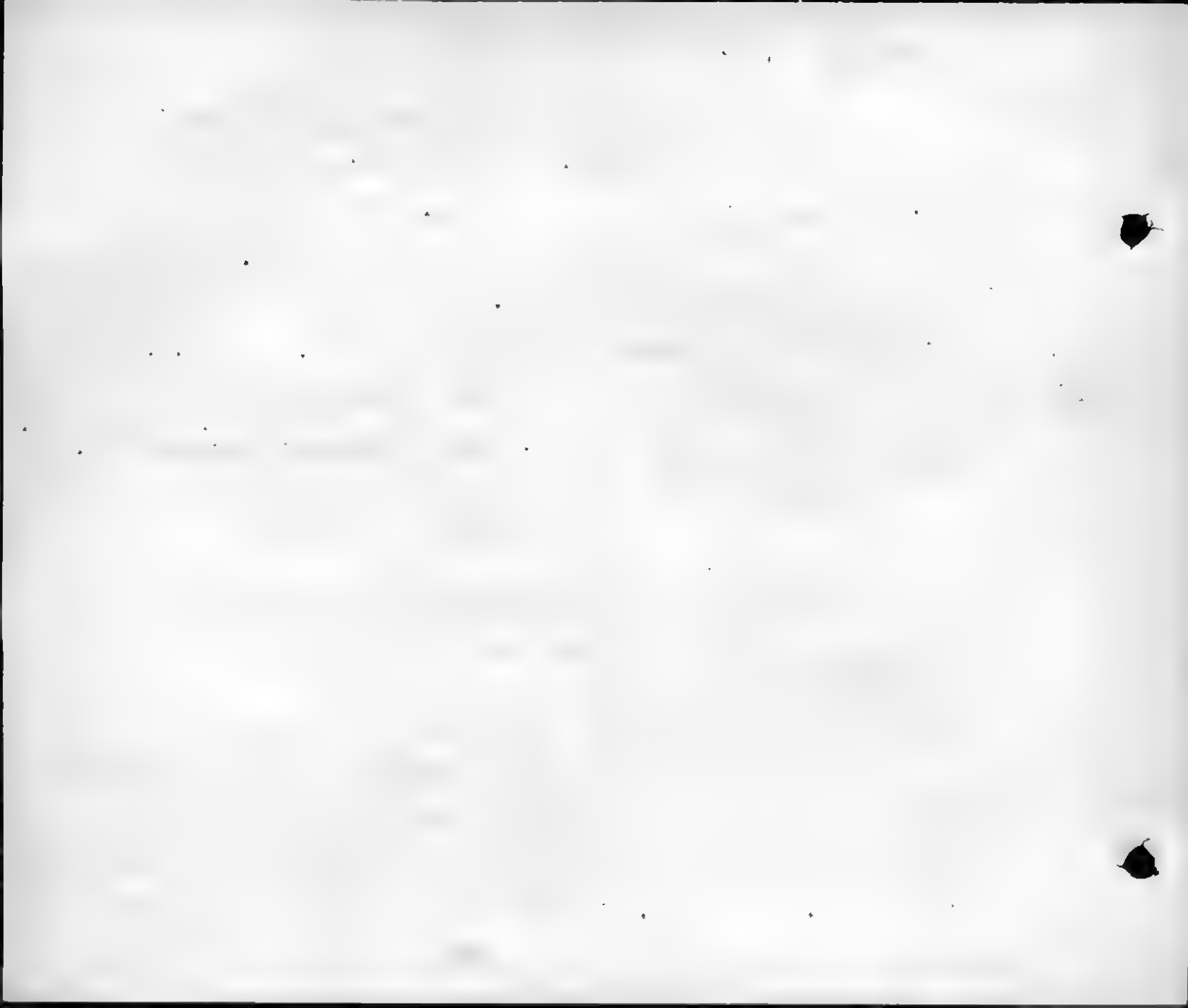
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9723

09674

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>				c. LENGTH OF STAY IN 1b <u>70 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 S. Mechanic Street</u>				d. STREET ADDRESS <u>107 S. Mechanic Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>May</u> Last <u>Mongan</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28 1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Keedysville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jonas Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Lopp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Paul Stockslager Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>One Day</u> <u>5 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 5, 1960</u> to <u>Aug 6, 1960</u> that (I) <u>lost</u> saw the deceased alive on <u>Aug 5, 1960</u> and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold E. Zimmerman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold E. Zimmerman</u>				22d. ADDRESS <u>Shepherdstown WVA</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 8 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Lee</u>				ADDRESS <u>Washington</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u>			



9708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09675

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Charleston</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charleston</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>300 S. Church St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>H.</u> Last <u>Osbourn</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1880</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (State or foreign country) <u>Charleston</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Laurence Osbourn</u>				14. MOTHER'S MAIDEN NAME <u>Clara C. Ashbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Paxson Whitmore</u> Address <u>300 S. Church St. Charleston W. Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Venous Thrombosis</u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (1) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>60</u> to <u>Aug 8</u> 19 <u>60</u> , that (u) (we) last saw the deceased alive on <u>Aug 2</u> 19 <u>60</u> and that death occurred at <u>2:30</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>M.E. Byrkit</u>				22b. DATE SIGNED <u>8-5-60</u>		22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>	
22d. ADDRESS <u>28 W Potomac Wght Md</u>				22e. REC'D BY REGISTRAR <u> </u>		22f. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>Aug 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EDGE HILL</u>		23d. LOCATION (City, town, or county) (State) <u>CHARLES TOWN W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lothar Munnich & Son Hagerstown Md</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



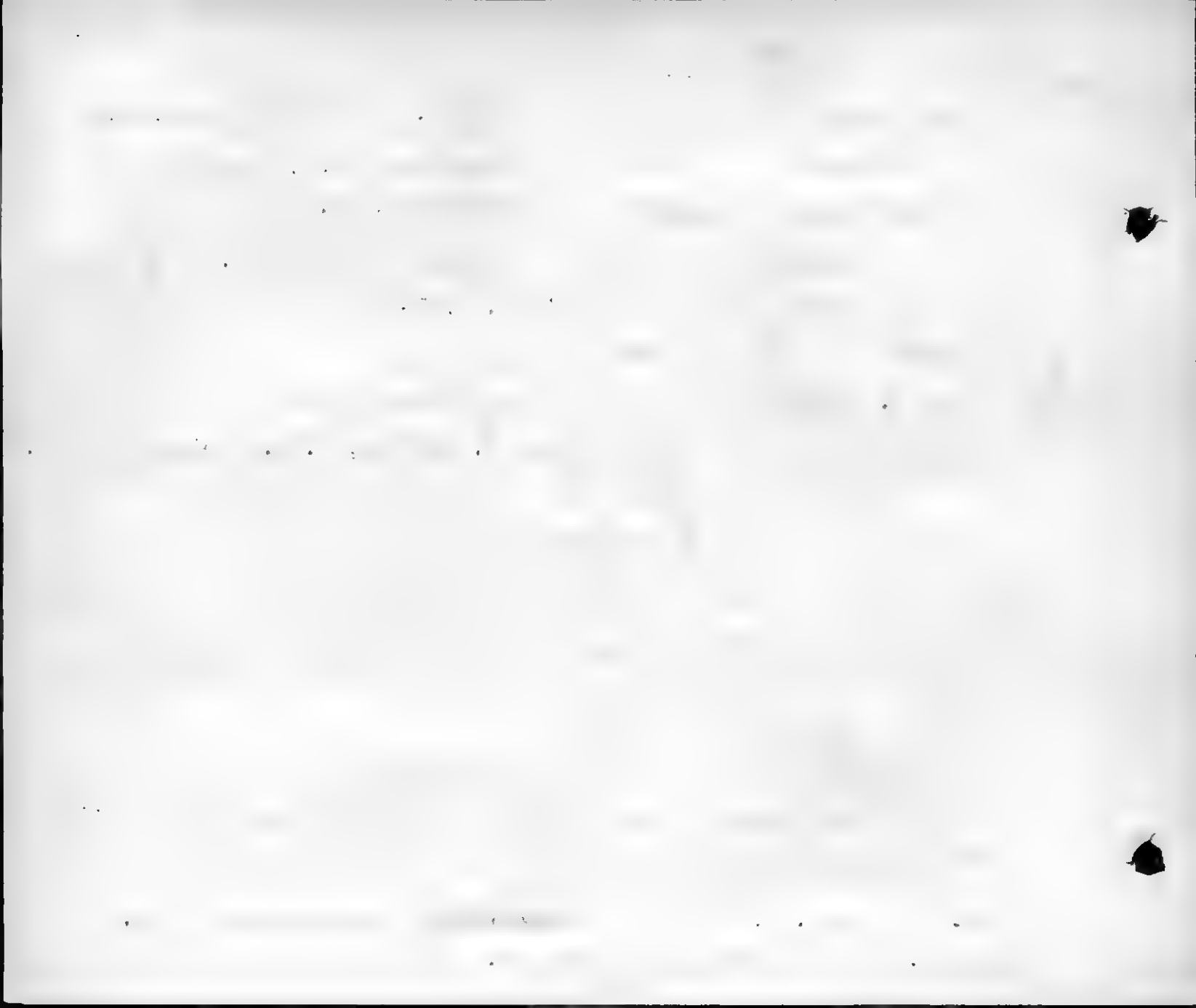
9685

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Samuel Portner				4. DATE OF DEATH Month Day Year Aug. 6 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1960	
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry E. Portner				14. MOTHER'S MAIDEN NAME Peggy Stottlemeyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. ADDRESS Harry E. Portner, R. D. 1 Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/4/1960 to 8/6/1960 that I last saw the deceased alive on 8/6/60 , 12, and that death occurred at 5:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. M. Bacon Jr				ADDRESS (Street, city or town, state) 701 King St / Hagerstown Md			
PHYSICIAN'S NAME (Type) A. M. BACON JR				DATE SIGNED 8/7/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1960		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetary		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			
ADDRESS Smithsburg, Md.				DATE AUG 9 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



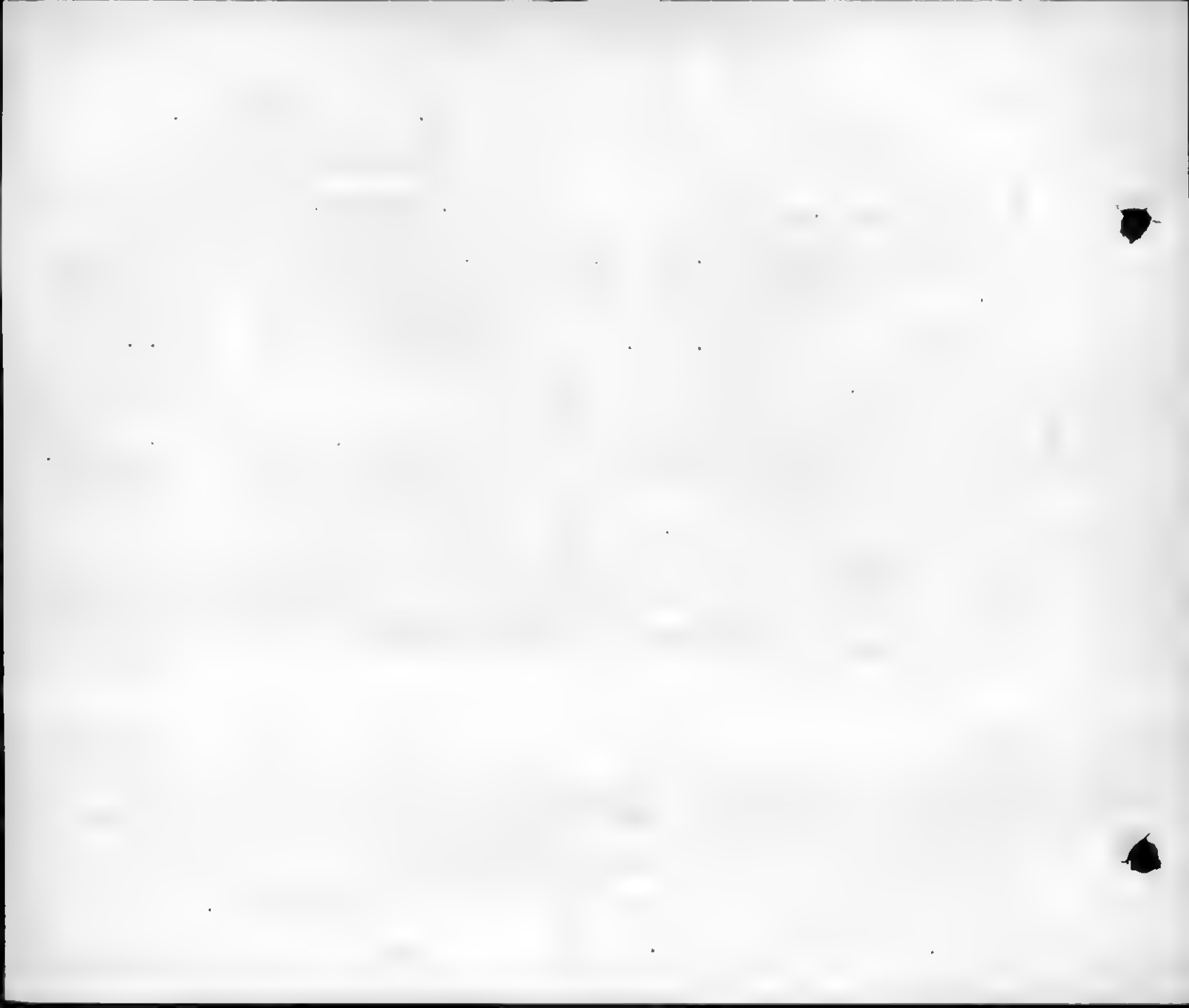
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

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9686
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09677

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MD. b. COUNTY WASH.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle D. Last POWELL SR.				4. DATE OF DEATH Month 8 Day 8 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 26, 1899		9. AGE (In years last birthday) yrs 61	10. IF UNDER 1 YEAR Months 8 Days 8 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM POWELL				14. MOTHER'S MAIDEN NAME MOLLIE GROVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 705-10-7095		17. INFORMANT ALBERT D. POWELL JR. Address 221 SUMMER ST. HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 11:20 A.M. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1958 to July 1960 , that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert V. H. Campbell M.D.				22b. DATE SIGNED 8/8/60		22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell	
22d. ADDRESS HAGERSTOWN MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/1960		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL		23d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS ADDRESS HAGERSTOWN, MD.				25a. REC'D BY REGISTRAR DATE AUG 10 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

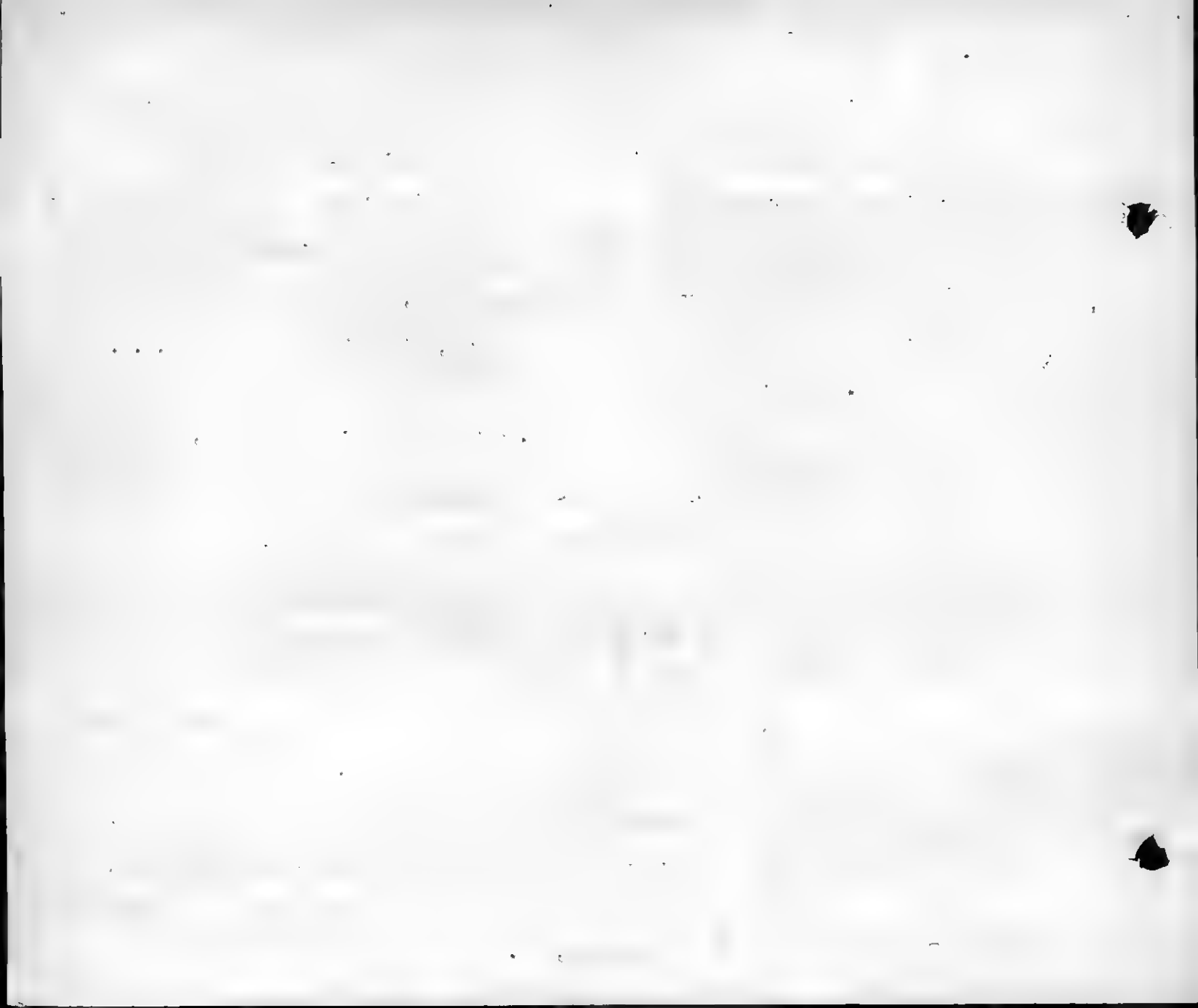
VR ATS (4)
 15M 9/59

9687

UNITED STATES DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09678

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 847 Rolling Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First THELMA Middle LORENA Last PURDHAM				4. DATE OF DEATH Month August Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1902		9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Luray, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter R. Miller				14. MOTHER'S MAIDEN NAME Louise Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. Josephine Coss Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral apoplexy DUE TO Arteriosclerosis cerebral. Conditions, if only, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; Obesity severe; fracture of hip 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 9 days
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in home -> hip fracture			
20c. TIME OF INJURY Month 7 Day 3 Year 1960 Hour 5 PM p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash Md.	
21. I certify that (I) (this hospital) attended the deceased from 7-30-60 to Death 19 60 , that (I) (we) last saw the deceased alive on 8-6-60 and that death occurred at 7:45 PM from the causes and on the date stated above							
22a. SIGNATURE Robert F. Keadle				22b. DATE 8-8-60		22c. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D.	
22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/10/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Boyer				25a. REC'D BY REGISTRAR DATE AUG 11 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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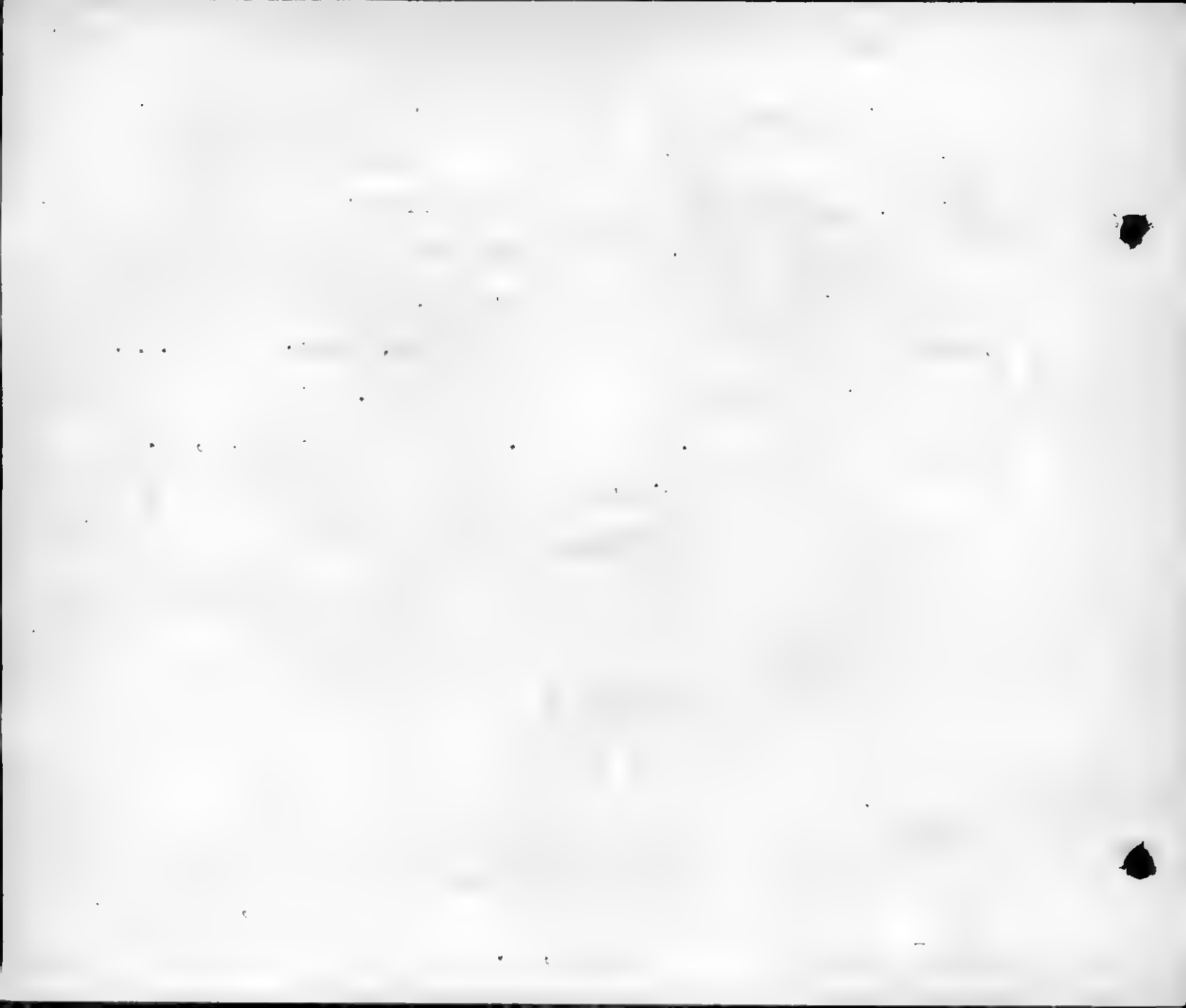
VR A15 (4)
ISM 9/59

9688

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09679

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 44 1/2 East Franklin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGIE Middle ALICE Last RAFFENSBERGER		4. DATE OF DEATH Month August Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 6, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months 17 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stotelmeyer		14. MOTHER'S MAIDEN NAME Mary J. Bowie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Robert Cashman Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse DUE TO (b) Cerebral hemorrhage DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH min 50 sec			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 5, 1960 to Aug 16, 1960 , that (I) (we) last saw the deceased alive on Aug 16, 1960 , and that death occurred at 31 M, from the causes and on the date stated above.			
22a. SIGNATURE L. S. [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Louis G. Gifford MD		22d. ADDRESS 119 E. Antietam St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/20/1960	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Super 7 Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
25a. REC'D BY REGISTRAR DATE AUG 23 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

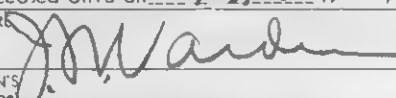
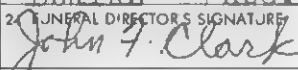

MARYLAND STATE DEPARTMENT OF HEALTH

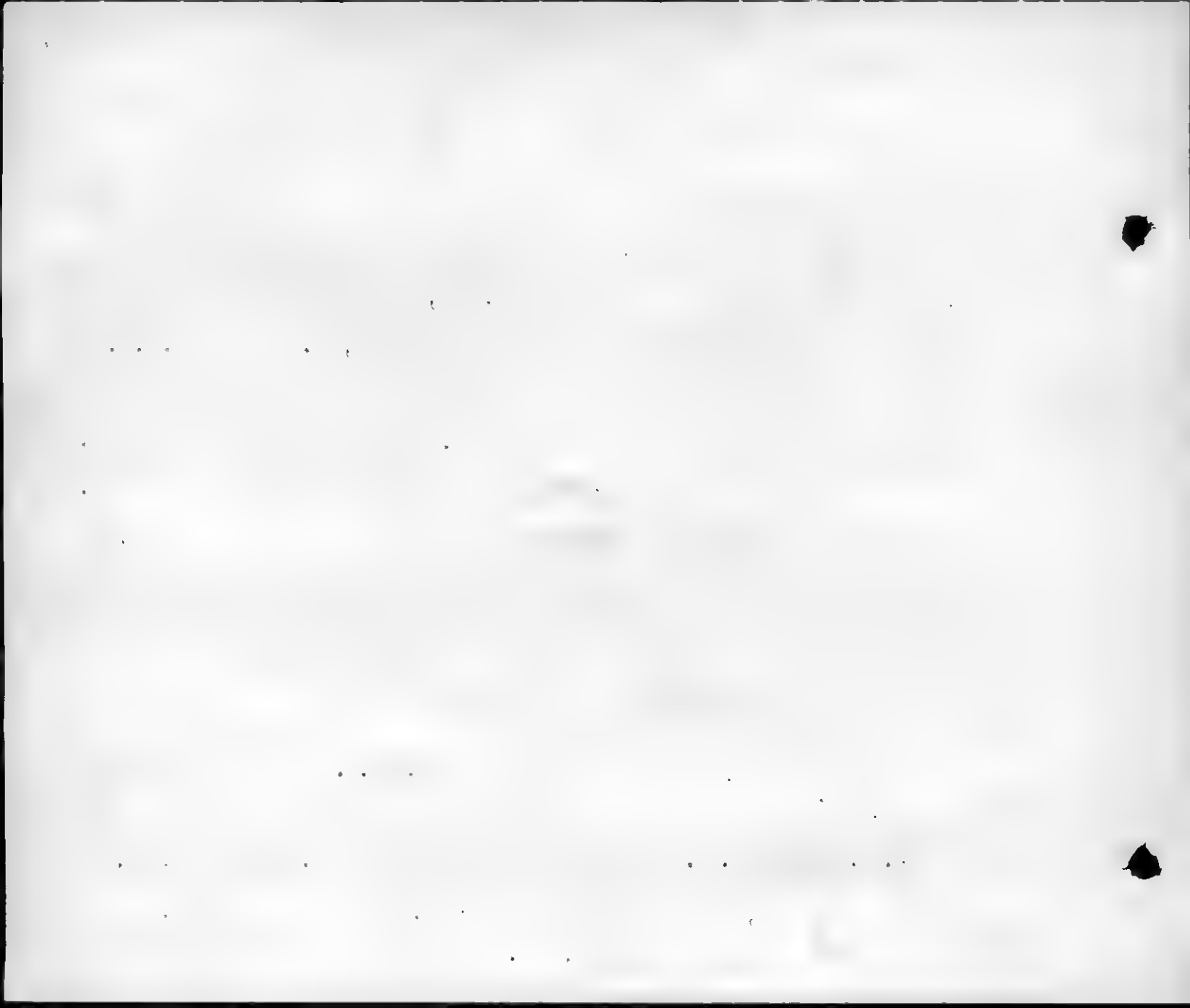
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9689

09680

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b FEW DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS NONE			
3. NAME OF DECEASED (Type or print) First JOHN Middle MARTIN Last SHOEMAKER				4. DATE OF DEATH Month AUGUST Day 25 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 19, 1871		9. AGE (In years lost birthday) 88 yrs	IF UNDER 1 YEAR Months 8 Days Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MILLSTONE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE SHOEMAKER				14. MOTHER'S MAIDEN NAME SUZANNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT OSCAR B. SHOEMAKER		Address HAGERSTOWN RD. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 177X (b) Carcinoma Prostate DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 7/4/56
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m Month 19 Day 19 Year 19 p. m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/4/56 to 8/25/60 , that (I) (we) last saw the deceased alive on 8/25/60 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 8/25/60		22c. PHYSICIAN'S NAME (Type) J. G. Warden, M. D.	
22d. ADDRESS 832 Potomac Ave., Hagerstown, Md.				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. ADDRESS 832 Potomac Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 28, 1960		23c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE CEM.		23d. LOCATION (City, town, or county) (State) MILLSTONE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR DATE AUG 29 '60		25b. REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09681

Reg. Dist. No. 302

9724

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro R # 1</u>		c. LENGTH OF STAY IN 1b <u>24 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro R # 1</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bakersville - Fairplay Rd</u>				d. STREET ADDRESS <u>Bakersville - fairplay Rd.</u>							
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>ELIZABETH</u> Last <u>SKELTON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>April 16 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Bakersville Wash Co Md.</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>John Sisler</u>			14. MOTHER'S MAIDEN NAME <u>Maggie Gaylor</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Mary J. Thomas Boonsboro R # 1</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>Bakersville - Fairplay Rd</u> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Involving Entire Face & Head</u> DUE TO (b) <u>(Self Inflicted)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Patient shot herself with shotgun.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient shot herself with shotgun.</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>9:15</u> o. m. <u>8-19-</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>							
20f. (City or town) <u>Boonsboro R # 1, Washington, Md.</u>		20g. (County) <u>Washington</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-20-60</u>							
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>							
22d. LOCATION (City, town, or county) <u>Bakersville Wash Co Md.</u>		22e. (State) <u>MD.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>AUG 23 '60</u>								
ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9690

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09682

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 31 years		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 220 Frederick Street				d. STREET ADDRESS 220 Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle ALBERTA Last SLICK				4. DATE OF DEATH Month August Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1895	
9. AGE (In years lost birthday) 65 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Wolfsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry G. Maugans, Sr.				14. MOTHER'S MAIDEN NAME Salie Ramsburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William H. Slick Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 pulmonary edema DUE TO (b) arteriosclerotic C.V.D. DUE TO (c) see your CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH see your							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/22/59 19 to 8/5/60 19, that (I) (we) last saw the deceased alive on 8/4/60 19, and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/6/60	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22d. ADDRESS 136 North Potomac Street Hagerstown, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kiser	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

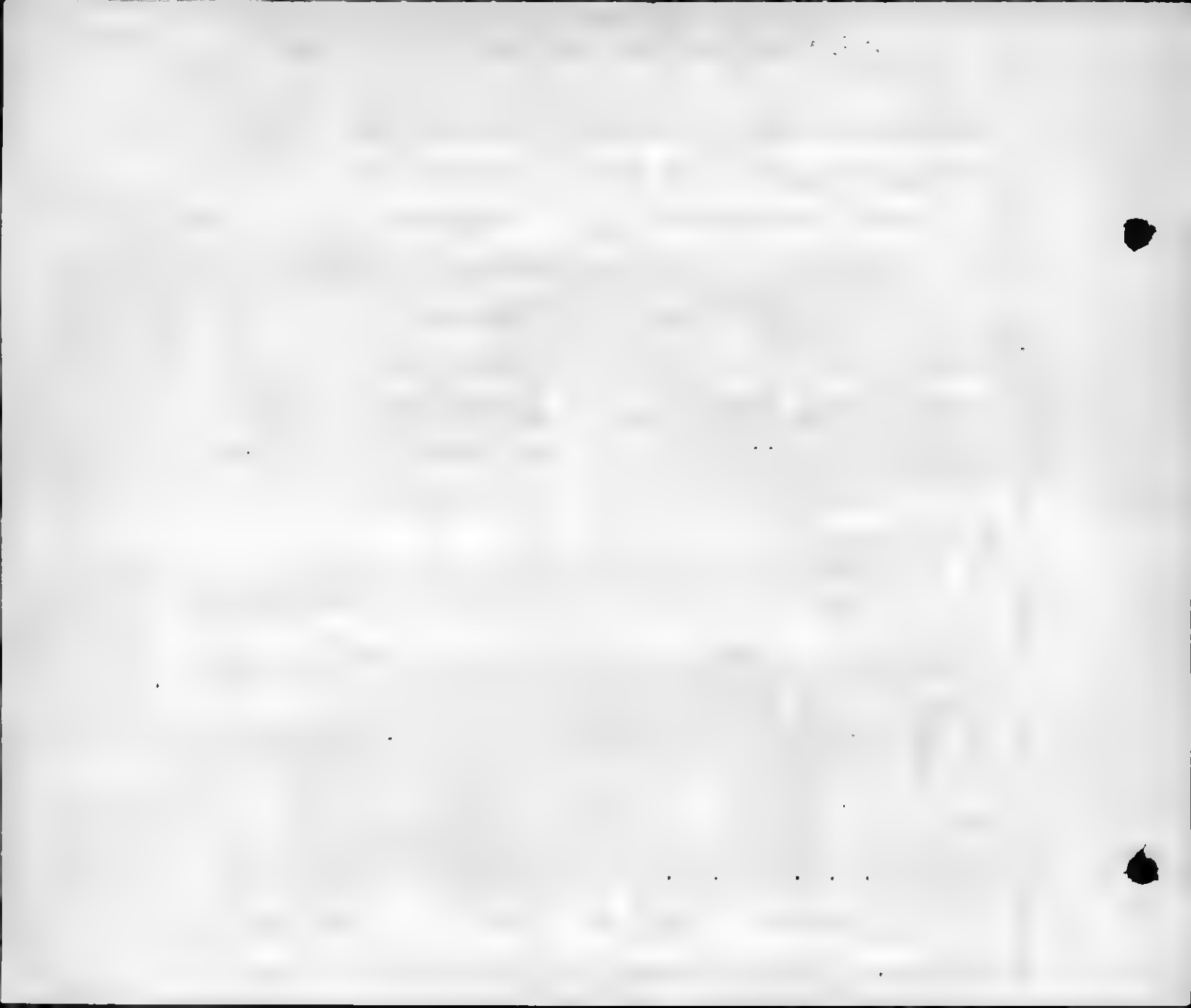
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9691

09683
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 10 Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY West Moreland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Latrobe d. STREET ADDRESS Route #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARLIN SCOTT SMITH				4. DATE OF DEATH Month Day Year August 21, 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1958	
9. AGE (in years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Elmer Smith				14. MOTHER'S MAIDEN NAME Evelyn Regina Hull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Eugene Smith, Route #3, Latrobe, Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Fracture Pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Left Femur DUE TO Cerebral Concussion (c) Probable Internal Injury						INTERVAL BETWEEN ONSET AND DEATH 11 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient struck by auto when he ran out on public road.			
20c. TIME OF INJURY Month, Day, Year Hour 5:45 p. m. 8-20- 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Walnut Point Road		20f. (City or town) (County) (State) Hagerstown, Washington, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8-22-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/60		22c. NAME OF CEMETERY OR CREMATORY Shanktown Cemetery		22d. LOCATION (City, town, or county) (State) Shanktown Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md				24a. REC'D BY REGISTRAR DATE AUG 24 '60		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9704

09738

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HALE WAY.</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MARQUE ALLEGING HOME</u>				e. STREET ADDRESS <u>17 GLENSIDE AVENUE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EFFIE MAY SPRECHER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 12 - 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 24 1878</u>	
9. AGE (In years last birthday) <u>87 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>3 18</u>		11. IF UNDER 24 HRS. <u>3 18</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CWNA HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WALNUT HUNT WASH. DC. MD. U.S.A</u>	
13. FATHER'S NAME <u>ANDREW J. HARSH</u>				14. MOTHER'S MAIDEN NAME <u>ANNA V. BUCHANAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NON</u>		17. INFORMANT <u>EDGARD SPRECHER</u> Address <u>17 GLENSIDE AVE WASH. DC. MD. U.S.A</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acc hyp. cardiac infarction</u> 4. 1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/4/60</u> to <u>8/12/60</u> , that (I) (we) last saw the deceased alive on <u>8/12/60</u> , and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Young</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/12/60</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>AUG. 15, 1960</u>		<u>ST. PAULS CEMETERY</u>		<u>HALESTOWN MD. Rte 146 WEST</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. West</u>				ADDRESS <u>1000 N. W. 10th St. N.W. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>Aug 18 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Fenn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/53

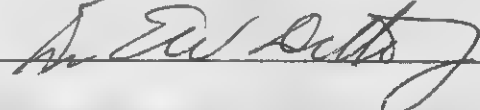

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 27 Red Oak Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last REV. AUGUST KARL STENZEL				4. DATE OF DEATH Month Day Year August 24 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27, 1912		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lutheran Minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August A. Stenzel				14. MOTHER'S MAIDEN NAME Matilda Johannigmeier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 492-03-C932		17. INFORMANT Mrs. Dora Stenzel		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO Coronary Occlusion Old & Recent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction Old & Recent DUE TO (c) Cardiac Hypertrophy						INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-24-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/1960		22c. NAME OF CEMETERY OR CREMATORY St. Trinity Lutheran Cem.		22d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE Super - Rouzer Funeral Home R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 26 '60	
				24b. REGISTRAR'S SIGNATURE 			

M

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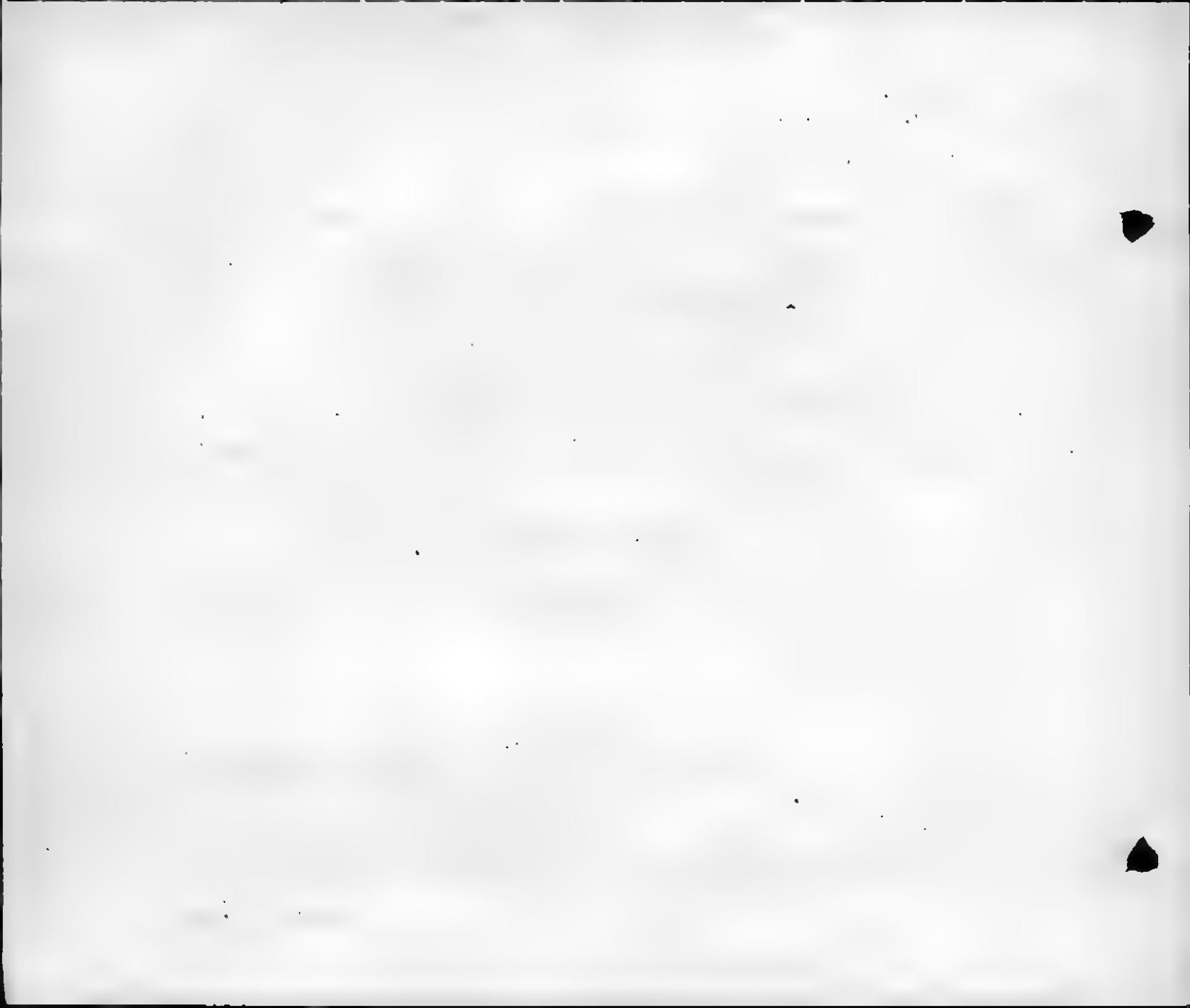
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

9725
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09685

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Penn.</u>		c. LENGTH OF STAY IN 1b <u>Chambersburg.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		d. STREET ADDRESS <u>- 5X</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Franklin</u> Middle <u>Stone</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1879</u>
9. AGE (In years, lost birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR: Mins <u>15</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fayetteville Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Stone</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Zentmyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>205-09-0417</u>	
17. INFORMANT <u>Amos D. Wenger</u>		Address <u>Chambersburg, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Dis.</u> 74- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Muscular Dystrophy</u> (b) DUE TO (c) <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 2, 1960</u> to <u>Aug 6, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 2, 1960</u> and that death occurred on <u>Aug 6, 1960</u> from the causes and on the date stated above			
22a. SIGNATURE <u>David R. Brewer</u>		22b. DATE SIGNED <u>8/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID R. BREWER</u>		22d. ADDRESS <u>Chambersburg, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Barbour</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 10 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 9/59

9693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09686

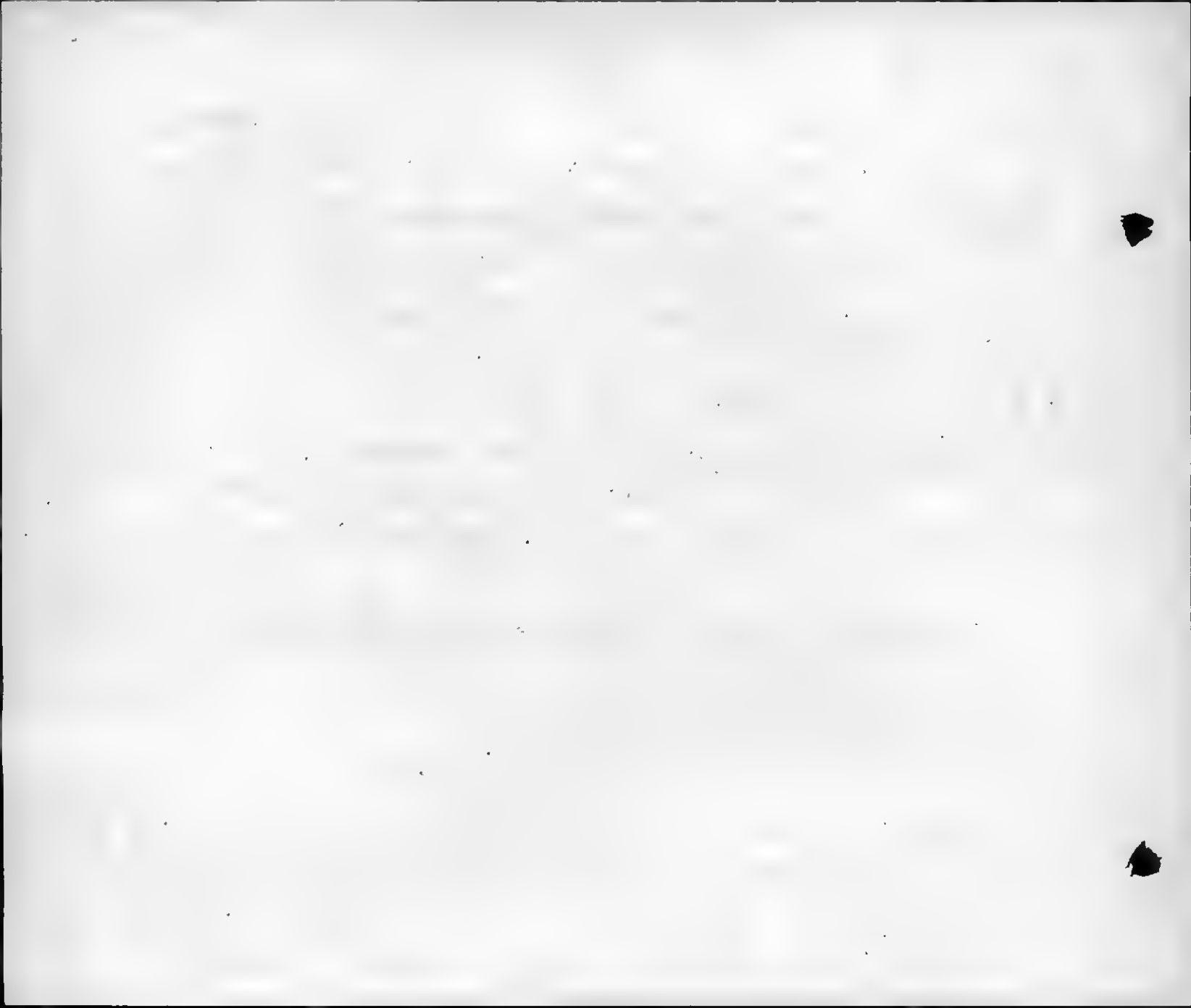
1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
c. LENGTH OF STAY IN 1b <u>2 wks</u>				d. STREET ADDRESS <u>7 South Carlisle st</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>V.</u> Last <u>Stumbaugh</u>				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 26 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>							
13. FATHER'S NAME <u>Russell S. Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Wagner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John W. Stumbaugh, Greencastle, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> DUE TO <u>Concussion</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mixed Cell Hemangioma</u> DUE TO <u>Perotid</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Aug 14 1960</u> to <u>Aug 15 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 14 1960</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.							
22a SIGNATURE <u>[Signature]</u>				22b DATE SIGNED <u>8/15/60</u>			
22c PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d ADDRESS <u>[Address]</u>			
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>8/17/1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Franklin Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	
ADDRESS <u>Greencastle, Pa</u>				DATE <u>AUG 17 '60</u>			

2 - 4
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9694
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09687

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2.</u>			
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Ann</u> Middle <u>SUMMERS</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 14 - 1874</u>		9. AGE (In years last birthday) <u>86</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>29</u> Hours <u>19</u> Min.	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10c. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>	
13. FATHER'S NAME <u>JOHN KLINE</u>				14. MOTHER'S MAIDEN NAME <u>MAGDALENE EASTERDAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>JOHN E. SUMMERS</u> Address <u>BOONSBORO MD. R. 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia, Bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease with congestive heart failure</u> DUE TO (c) <u>Unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema, Diabetes mellitus, Pyelonephritis.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1960</u> to <u>Aug. 29, 1960</u> that (I) (we) last saw the deceased alive on <u>Aug. 29, 1960</u> and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u> M.D.				22b. DATE SIGNED <u>Aug. 29, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 1, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. CARMEL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Mt. CARMEL WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

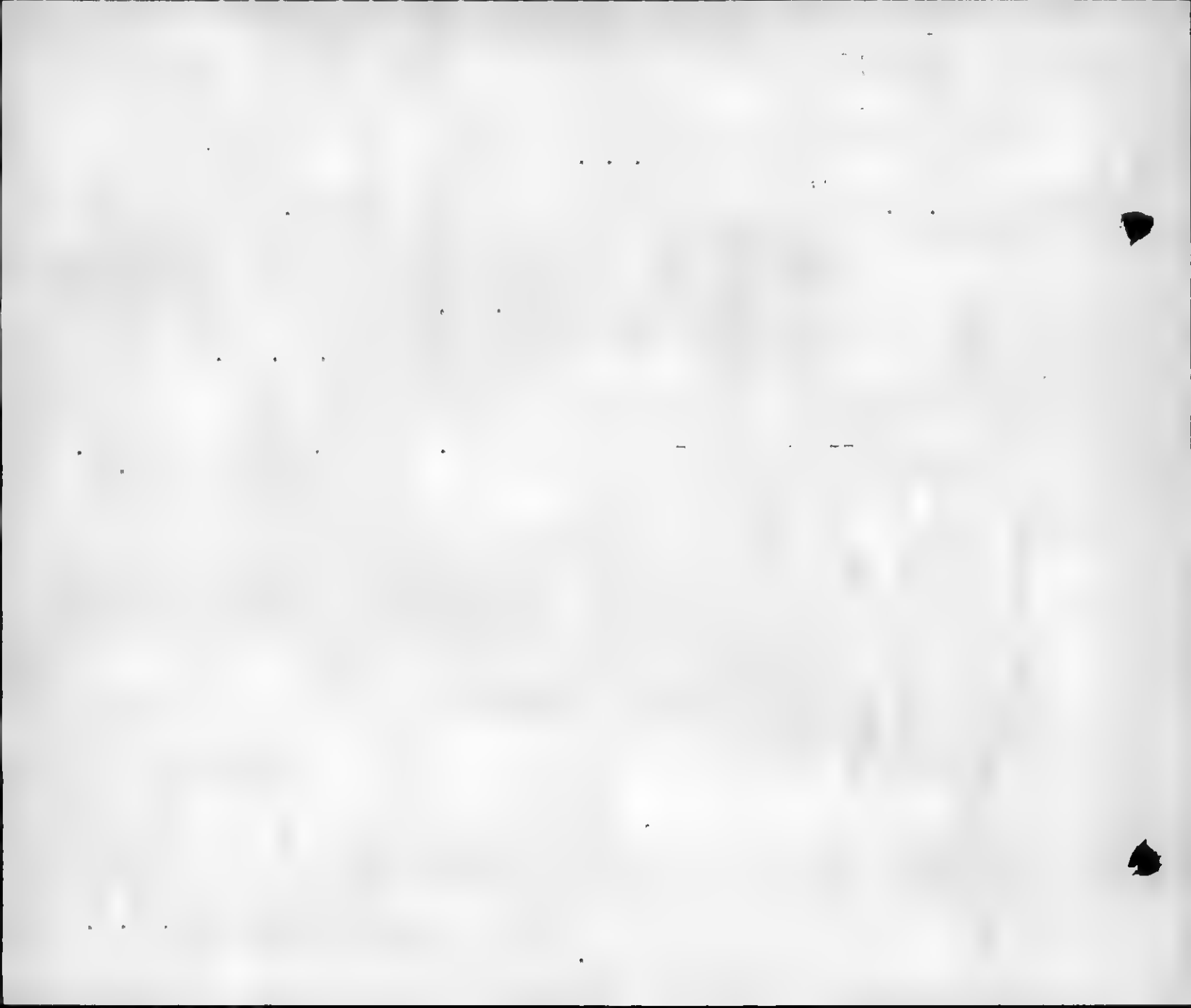
9695

Reg. Dist. No.

09688

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash.Co.Hospital</u>				d. STREET ADDRESS <u>838 Chestnut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA AMELIA TEMPLON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> , Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1912</u>	
9. AGE (in years last birthday) <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Percy Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-40-0372</u>		17. INFORMANT Address <u>Frank J. Templon, 828 Chestnut St., Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>+20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerosis</u> DUE TO (c) _____</p> </div> <div style="width: 25%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Howard H. Weeks, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>HOWARD H. WEEKS, M.D.</u>				DATE SIGNED <u>8/19/60</u>			
22a. BURIAL, CREMAT ON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hunt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the attending physician or the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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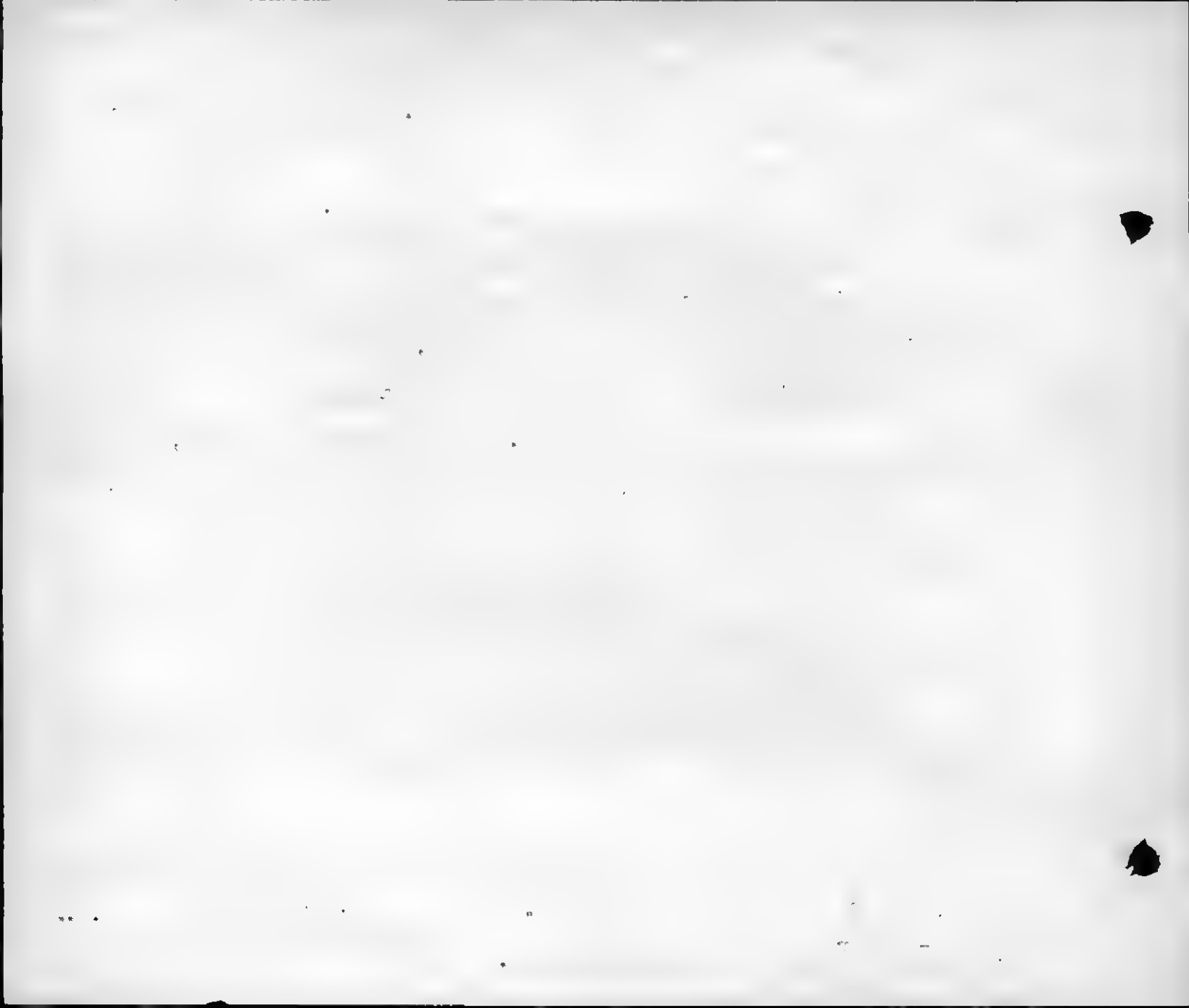
11

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09689

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				d. STREET ADDRESS 1845 Mulberry Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gertrud Luise Thost				4. DATE OF DEATH Month Day Year Aug. 1 1960			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH October 10, 1877	
9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Zwickau, Germany		12. CITIZEN OF WHAT COUNTRY? German	
13. FATHER'S NAME Wilhelm Sonntag				14. MOTHER'S MAIDEN NAME Lydia Grosse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17 INFORMANT Address Mrs. Hertha Altmann Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis, general DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cardiac hypertrophy							INTERVAL BETWEEN ONSET AND DEATH 22 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 15, 1960 to Aug. 1, 1960 , that (I) (we) last saw the deceased alive on Aug. 1, 1960 , and that death occurred at 5:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Aug. 2, 1960	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos				22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/3/1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE W. Franklin Boyer				25a. REC'D BY REGISTRAR DATE AUG 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Fennell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

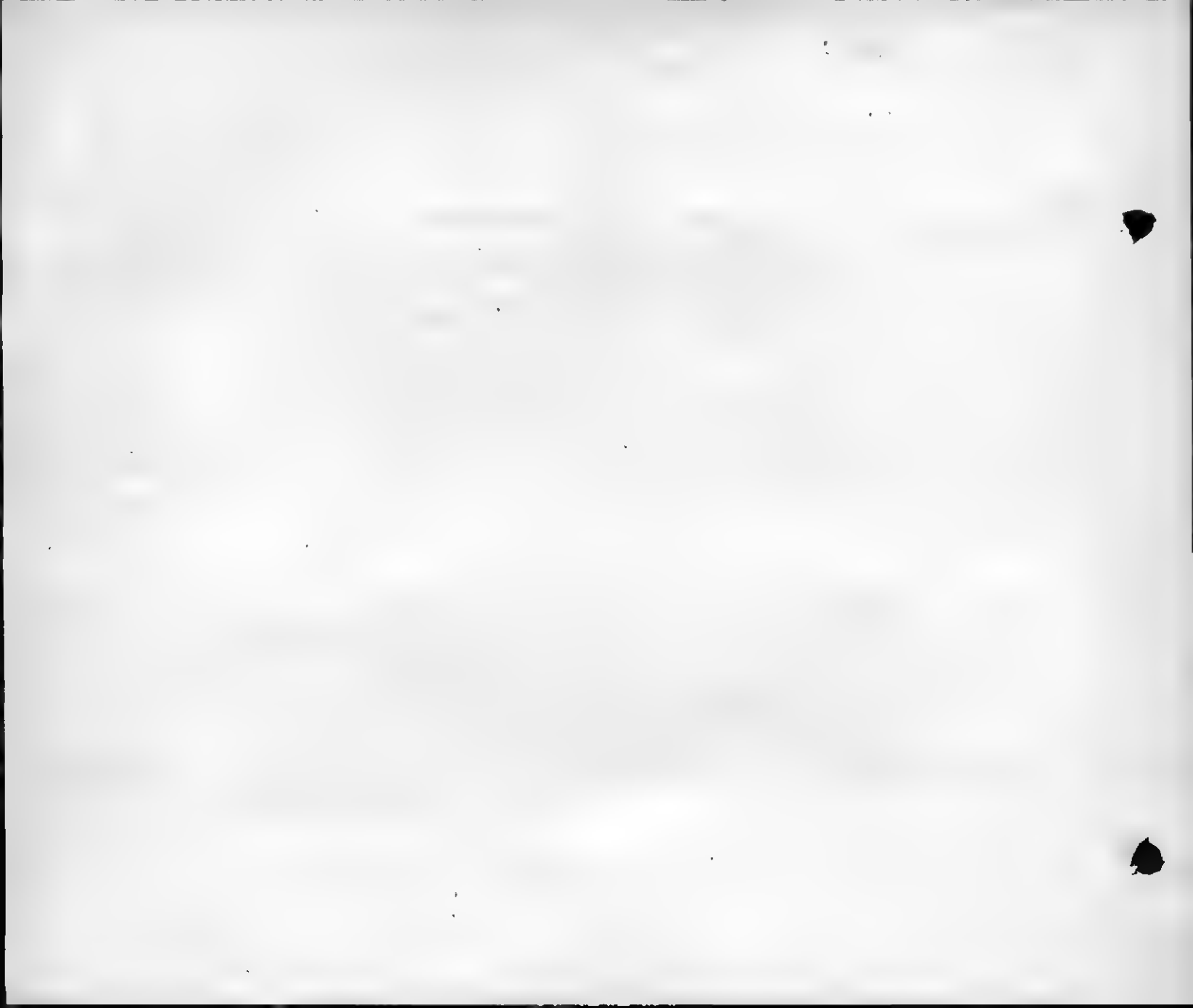
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9697

09690

1 PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				d. STREET ADDRESS <u>Route 4CA - NORTH</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>LESLIE HARBAUGH VALENTINE</u>				4. DATE OF DEATH Month Day Year <u>AUGUST - 4 - 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH - 16 - 1884</u>	9. AGE (In years last birthday) <u>76 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min <u>4 18</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TOOL GRINDER - JAMISON COLD STORAGE DOOR CO. WAYNESBORO PENNA</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>REUBEN VALENTINE</u>				14. MOTHER'S MAIDEN NAME <u>MARY STULL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-09-9756</u>		17. INFORMANT Address <u>MRS. MARY VALENTINE BOONSBORO MD. R.I.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Haemorrhage</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs 10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21 I certify that (I) (this hospital) attended the deceased from <u>July 26</u> 19 <u>60</u> to <u>Aug. 4</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> 19 <u>60</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. He Van</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>G. W. He Van</u>				22d. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>AUG 7 - 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BEAVER CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BEAVER CREEK WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 10 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



9698

CERTIFICATE OF DEATH

09691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORENE</u> Middle <u>TATE</u> Last <u>WALKER</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1911</u>
9. AGE (In years last birthday) <u>49</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done; list most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Lena Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-16-7194</u>	
17. INFORMANT <u>Brooksie Brown - sister</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>171X</u> DUE TO <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO <u>Subacute & Chronic Pyelonephritis</u>		<u>18 mo</u>	
DUE TO <u>Carcinoma of Cervix</u>		<u>3 1/2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Pericarditis; Lobular Pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 29, 1960</u> to <u>Aug 30, 1960</u> that I last saw the deceased alive on <u>Aug 30, 1960</u> and that death occurred at <u>9:40 PM</u> My from the causes and on the date stated above			
ACTUAL SIGNATURE <u>I. B. Lyon</u>		DATE SIGNED <u>8/31/60</u>	
PHYSICIAN'S NAME (Type) <u>I. B. Lyon</u>		ADDRESS (Street, city or town, state) <u>1800 Rausy/Vanna Ave Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-3-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

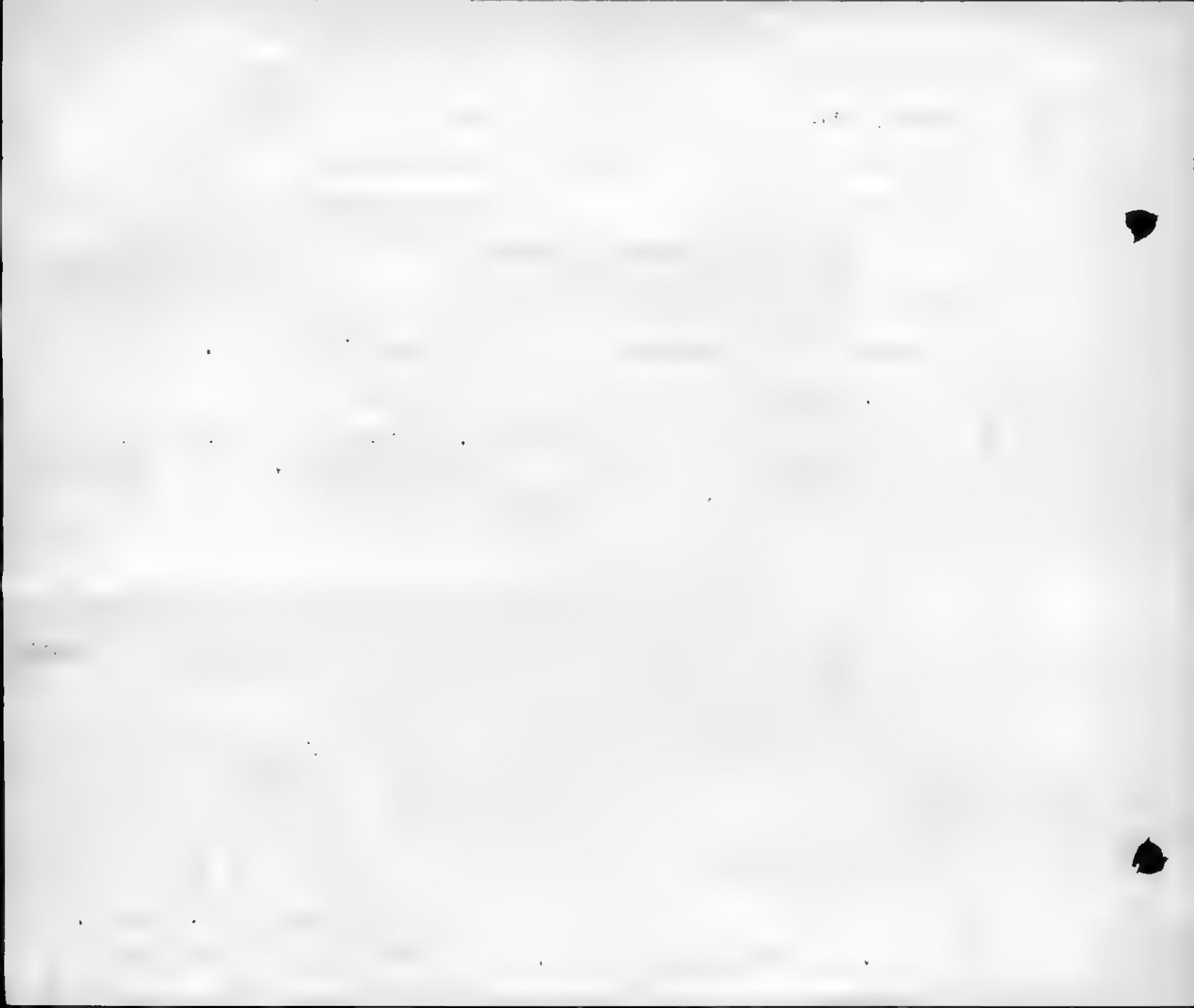
9699

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

302

09692

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Days d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 423 Summit Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle BACKER Last WARNER Sr				4. DATE OF DEATH Month August Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14 1890	
9. AGE (In years last birthday) 70 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James B. Warner				14. MOTHER'S MAIDEN NAME Susan Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-09-7260		17. INFORMANT Harry B. Warner Jr 423 Summit Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertensive Cardio Vasc. disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 72 hrs. 4 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1950 to Aug 8, 1960 , that (I) (we) last saw the deceased alive on Aug 8, 1960 and that death occurred at 11:30 M, from the causes and on the date stated above							
22a. SIGNATURE Robert P. Conrad				22b. DATE SIGNED 8-9-60		22c. PHYSICIAN'S NAME (Type) Robert P. Conrad	
22d. ADDRESS Hagerstown, 777d.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) Hagerstown Wash Co Md. (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. ADDRESS Hagerstown Md.		24b. REC'D BY REGISTRAR AUG 15 '60	
24c. REGISTRAR'S SIGNATURE Arthur S. Howard				24d. DATE AUG 15 '60			



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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9700

09693

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 229 Woodpoint Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARK Middle ELWOOD Last WILHIDE				4. DATE OF DEATH Month August Day 24 Year 19 60					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1960		9. AGE (In years last birthday) yrs. 19	IF UNDER 1 YEAR Months 19 Days 27	IF UNDER 24 HRS. 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Elwood Wilhide				14. MOTHER'S MAIDEN NAME Gail Lee Silvernail					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. D. E. Wilhide Address 229 Woodpoint Ave. Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last, (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Congenital Deformities								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -		
21. I certify that (I) (this hospital) attended the deceased from Aug. 23, 1960 to Aug. 24, 1960 , that (I) (we) last saw the deceased alive on Aug. 23, 1960 and that death occurred at 6:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE John D. Turco				22b. DATE SIGNED 8-25-60		22c. PHYSICIAN'S NAME (Type) Dr. John D. Turco		22d. ADDRESS 302 N. Potomac Street - Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/25/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR AUG 26 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kneale	

Wm. A. Hawk



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9701

09694

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				e. STREET ADDRESS 935 Hamilton Boulevard			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NETTIE BARBARA WOLFE				4. DATE OF DEATH Month Day Year August 9 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1869		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Wolfe				14. MOTHER'S MAIDEN NAME Rachael Hawthorne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-14-6420		17. INFORMANT Address Mrs. Carlotta Keller Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-9-1959 to 8-9-1960 that (I) last saw the deceased alive on 8-7-1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Dalton M. Welty				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.	
22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/11/1960		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

100000

UNITED STATES DEPARTMENT OF AGRICULTURE

1010



Washington, D. C., August 1, 1901

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 27th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours very truly,

J. B. Thompson, Secretary

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated July 27, 1901.

Very truly,
J. B. Thompson



Very truly,
J. B. Thompson

Very truly,
J. B. Thompson

TO DENITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9726

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G271 9-15-60 et

09695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u>		c. LENGTH OF STAY IN lb <u>5 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Stuart</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5.19.1907</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Narragansett R.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W Wood</u>		14. MOTHER'S MAIDEN NAME <u>Delia Schmidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>War War 11</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Joseph Wood 116 Moore St. Princeton N.J.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis, Severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (c) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		DATE SIGNED <u>9-2-60</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9.7.60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National VA Arlington VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold J. Skone</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>	
ADDRESS <u>Hancock Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Flann</u>	

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Age: _____
3. Sex: _____
4. Race: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Manner of death: _____
9. Signature of Medical Examiner: _____
10. Signature of Coroner: _____
11. Signature of Physician: _____
12. Signature of Nurse: _____
13. Signature of Undertaker: _____
14. Signature of Witness: _____
15. Signature of Juror: _____
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